ABSTRACT

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A COMPARATIVE ANALYSIS BETWEEN AFRICAN AMERICAN WOMEN AND CAUCASIAN WOMEN: HEALTH SEEKING BEHAVIORS, ATTITUDES, PERCEPTION, SUSCEPTIBILITY, SEVERITY, BARRIERS, AND MEDICAL BENEFITS REGARDING BREAST CANCER

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The objective of this study was to examine if there was a relationship between African American women and Caucasian women regarding breast cancer. To determine this objective, the following areas were explored by the researcher: (a) health seeking behaviors, (b) perception, (c) attitudes, (d) susceptibility, (e) severity, (f) barriers, and (g) medical benefits.

In this study, an exploratory research was used. A sixty-six item questionnaire was administered by the researcher. The questionnaire was given to a group of fifteen African American women and fifteen Caucasian women ranging in age from thirty-five to fifty-five. The population was selected from two churches: Liveoak Baptist Church located in College Park and Church of Christ Forest Park located in Forest Park.

The results of the study revealed that there is no statistically significant relationship between African American women and Caucasian women: health seeking behaviors, perception, attitudes, susceptibility, severity, barriers, and medical benefits regarding breast cancer. The hypothesis was rejected for this study.

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TABLE OF CONTENTS

PAGE

Table of Contents (*Continued*) PAGE

LIST OF TABLES

List of Tables *(Continued)*

List of Tables *(Continued)*

List of Tables *(Continued)*

List of Tables *(Continued)*

CHAPTER ONE

INTRODUCTION

Tremendous energy, vast funding, and great strides are being committed to breast cancer research, which promises one day to cure and eradicate this disease. Unfortunately, one in eight women will develop breast cancer in their life span (Black Women Health, 1999). This exploratory study will examine the differences between African American women and Caucasian women health seeking behaviors, perception, attitudes, susceptibility, severity, barriers, and medical benefits regarding breast cancer.

There are several issues associated with breast cancer. One important issue is the difference in social and cultural beliefs among different ethnic groups. The observed racial differences in cancer survival are primarily due to socioeconomic factors, including variables such as low education, undernourishment, greater risk-promoting life styles, and less access to the health care system according to a report by the American Cancer Society (Williams, Abbott and Taylor, 1993). Due to these factors and other problems, there has been great difficulty in reaching African American women, especially ages 50 and older. The risk of breast cancer increases with age (Black Women Health, 1999). Some of these women believe they are not susceptible to breast cancer (Forte, 1995). Therefore, if these women do not believe they are not susceptible, it may contribute to the failure to seek professional help.

It is not known whether the difference in illness patterns between African American women and Caucasian women is due to health socialization or differences in ethnic lifestyles. But it is important for social workers to understand that the traditional health services available to African American women greatly need improvement. Even though our health care system is one of the world's most costly; our lack of breast cancer treatment for women in the African American community is very low. There are other women's health issues that call for improved standards of treatment as well.

The situation out of which the problem evolves for the researcher was influenced by a family member. She was diagnosed with breast cancer. Similar to some of the women in the study, the researcher had some of the same misconceptions. For example, this African American female social work intern thought that relatives were not at risk due to no family history of breast cancer; self-examinations were not important; breasts were for sexual pleasure; and the disease was someone else's problem and responsibility. Typically, when an issue effects one's life, then it becomes a concern. Considered once a taboo topic, now the profession of social work supports the importance of early detection.

Additionally, to gain further understanding, knowledge, and education on breast cancer, the researcher has become involved in several ways. As a social work intern, this researcher visited a breast cancer facility. The African American female director provided studies conducted within the Atlanta communities. As a breast cancer survivor, the director emphasized the great need for African American women to become more knowledgeable about breast cancer. Furthermore, the researcher has supported the cause with reading current nonprofessional/professional articles, workshops, donations, usage

of breast cancer postage stamps, purchase of breast cancer items, volunteered and participated in the "Race for the Cure," and this extensive research paper. As an African American female at risk and social worker, it is an ethical and personal desire to further close the gap in knowledge and help further and contribute to other studies.

This exploratory thesis will address the gap in social work knowledge concerning breast cancer as well as discuss effective and appropriate interventions for African American women. The hope for the study is to contribute to social empirical research, offer practical and culturally appropriate interventions for African American women, and to galvanize the social work profession into positive actions.

Fortunately, the family member was a survivor of breast cancer. Ironically, the disease did not take the family member's life, but the disease took the researcher's attention. The researcher learned when it becomes a personal issue, then it becomes a problem worth giving attention. Although the researcher was not present to support the significant other, hopefully, this thesis will help someone else. As a social work practitioner, it is a professional, personal, and ethical duty to improve the quality of life. In conclusion, social work can be used as a vehicle to turn this unseemingly issue into educating, mediating, and advocating for the undeserved and at risk population.

Statement Of The Problem

This exploratory study will examine factors associated with African American women and Caucasian women survival rate of breast cancer. This thesis will further examine several areas: if a relationship exists between health seeking behaviors, perception, attitudes, susceptibility, severity, barriers, and medical benefits regarding

breast cancer. Each of these variables makes a social and cultural impact on African American women and Caucasian women regarding breast cancer.

The manner in which these women mentally internalize social information, as a result, the internalize social information affects their behavior. Usually, the information regarding breast cancer which society offers is sometimes tainted with racism. Therefore, due to racism, these women will have culturally different responses. As a result, African American women and Caucasian women will culturally and socially behave differently. In essence, this study will look at the correlation between the variables and under what conditions they affect the psychosocial factors for African American women and Caucasian women.

There are many issues, which lead to the overall problem of why African American women when compared to Caucasian women have a lower survival rate of breast cancer. One problem is many African American women do not routinely visit the doctor. Sometimes, women become emotionally disable and crippled by the thoughts of death from breast cancer. Furthermore, the emotional stress breast cancer brings to women, their family and friends can bring denial and can discourage women from seeking medical treatment. Unfortunately, there are significant risks and negative consequences if a woman does not routinely seek medical attention. Even more, fifty percent of women who get breast cancer have no identifiable risk factor beyond gender and age (Black Women Health, 1999). An estimated 175,000 this year will hear the diagnosis, "You have breast cancer," and 43,300 will die from it (Black Women's Health, 1999). Also, African American Women were 2.2 times less likely to survive breast

cancer than Caucasian Women, according to a National Cancer Institute Study (Black Women's Health, 1999). Another issue that surrounds breast cancer is economical factors. Some women are uninsured or underinsured which is an obstacle in receiving mammograms. Consequently, the timing of an intervention can make a difference between an early and late prognosis.

Ironically, many physicians are perpetuating the problem of breast cancer. The problem is that physicians are not referring African American women for mammograms as frequently as Caucasian women (Forte, 1995). As a result, African American women continue to have a distrusting response towards the medical field and mainstream society. Another issue is when the standards of care have been breached by the physician. In other words, did a misdiagnosis cause the patient more harms? Furthermore, what are the legal implications of this malpractice? Social workers need to understand and must address breast cancer and other complicated issues that are inherited with this disease.

These previous issues contribute to the overall problem of low survival rate of breast cancer for African American women. African American women have a low risk for developing breast cancer, however, these women have poorer outcomes which is not completely understood (Black Women's Health, 1999). Although, there are differences between African American women and Caucasian women regarding health seeking behaviors, perception, attitudes, susceptibility, severity, barriers, and medical benefits for breast cancer, one must look at the extraneous variable which encourage these cultural differences. Social workers need to know external factors which influence African American women such as: why these women are not routinely visiting the doctor, the

economic factors and lack of resources in the Black community, why Black women are uninsured or underinsured, lack of physician referrals, and how community-based organizations must learn how to reach this population through unconventional means.

Significance And Purpose Of The Study

Although there are many issues surrounding breast cancer, the significance and purpose of this study is to conduct a comparative analysis of African American women and Caucasian women regarding health seeking behaviors, perception, attitudes, susceptibility, severity, barriers, and medical benefits for breast cancer. The researcher will present characteristics to demonstrate a significant difference of lifestyle and beliefs between Caucasian women and African American women, which impacts their survival rate of breast cancer. This study will discuss how a person's belief system and a person's choices of behavior can determine one's lifestyle. Therefore, the researcher will address the gap of knowledge concerning different beliefs, lifestyles, and factors.

The purpose of this research is to create innovative ways, which will effectively and appropriately intervene to increase the survival rate for African American women. This study is important to the social work profession because social workers can educate, advocate, effectively intervene, and help formulate policy regarding breast cancer. First, social workers should find innovative ways to target high risk population groups. Since African American women are a high risk population, as social workers, we must "meet the client where the client is." For example, social workers can go to places that African American women frequently visit and informally speak with these women about high risk

behaviors of breast cancer. These places could be church, salons, social agencies, malls, and grocery stores, to name a few.

Additionally, social workers can help formulate policy on breast cancer. Having the clinical practice from the micro level and mezzo level, social workers are able to bring their expertise to the macro level. The social worker is able to represent and share their well informed opinion and clinical expertise from working with individuals, medical staff, communities, and researchers. Skilled and trained social workers would be revered and respected because of their clinical practice and knowledge base they bring to the table.

In conclusion, this study is significant to social workers because this study can be a source of knowledge; this study can show social workers the need to make an impact in another area; and it is this area where social workers can advocate and educate the community. Also, social workers are key players in the fight against breast cancer because of their ability to switch from one role to another and the knowledge base social workers possess.

CHAPTER TWO

REVIEW OF THE LITERATURE

This literature will review the following significant concepts: health seeking behaviors, perception, attitudes, susceptibility, severity, barriers and medical benefits. This chapter will also include consideration of the major theoretical framework, definition of terms, and the hypothesis of the study.

Health Seeking Behaviors

In order to fully understand health seeking behaviors, the statistical background will be examined to bring further clarity of behaviors between African American women and Caucasian women regarding breast cancer.

According to Komen Breast Cancer Foundation during 1996, 178,700 new cases were diagnosed and 43,500 women died from breast cancer (1998). Caucasian women had an overall incidence rate of 114.5 per 100,000, however, African American women were 110.5 per 100,000 (Komen, 1998). On the other hand, African American Women had a mortality rate of 31.5 per 100,000 compared to 26.0 per 100,000 for Caucasian women (Komen, 1998). Moreover, African American women had a 5-year survival rate of 70.6% compared to 86.7% for Caucasian women. Ironically, these statistics show obvious contradictions in overall incidence rates, mortality rates, and survival rates.

Analyzing the statistics, African American women (younger than age 50) have a lower incidence rate of breast cancer than Caucasian women. However, African American women have a higher mortality rate than Caucasian women. Furthermore, Caucasian women have a better survival rate than African American women do.

As a woman grows older, so does the incidence and mortality of breast cancer increases. Each year 76.8% of women over the age of 50, are newly diagnosed with breast cancer (Komen, 1999). However, breast cancer is rare in younger women. Women ages 20-24 have an incidence rate of only one case per 100,000 (Komen, 1999). Unfortunately, as the woman grows older the risk of breast cancer increases. For example, 25 cases for women ages 30-34, 121.7 cases for women ages 40-44, and 244.8 cases for women ages 50-54 (Komen, 1999). One study suggests that cancer control interventions targeted to elderly disadvantaged women, particularly minorities, have the potential to decrease avoidable cancer morbidity and mortality (Mandelblatt, 1991).

There is a large gap between African American women and Caucasian women with mortality trends. Breast cancer mortality rates increased 1.5% among Caucasian women and 15.6% among African American women from 1973 to 1989 (Komen, 1999). Hence mortality rates among Caucasian women declined 6.1% as rates among African American women declined 1% (Komen, 1999). Overall, African American women have a 31.5 per 100,000 mortality rate compared to 26.0 for Caucasian women (Komen, 1999). According to the Female Breast Cancer Mortality Rates per 100,000, 1990-1995 Caucasian women 26.0, African American 36.5, Hispanic 15.3, and Asian/Pacific Islander 11.7 are the statistics. Several factors may cause breast cancer mortality in both

racial groups. According to some research, African American women may be diagnosed with breast cancer in later stages. Also, there could be limited access to medical care, financial resources, or other cultural factors.

Generally, the medical and academic research community does not understand the medically underserved and understudied. Many of African American women are from underserved and underfunded health care institutions. For example, African Americans used the physicians' offices 16% less than Caucasians which is 263 vs. 312 visits per 100 persons (ACS, 1996). Studies suggest an association between knowledge, social status, attitudes, and behaviors regarding health issues. Persons with low income are less knowledgeable about illness and disease, hard to recruit for screening and other health services, and delay seeking medical care.

There is a better prognosis when breast cancer is detected early. Early diagnosis increases treatment options and may reduce breast cancer mortality. The most sensitive and promising of early detection methods is screening mammography. Currently, mass screening for breast cancer is the only way to significantly affect the rate of breast cancer deaths. Price et al., (1992) states there are 48 million women at risk of developing breast cancer but only 15 percent have had a mammogram. African American women are less likely to have a mammogram. One-half million American women have undiagnosed breast cancer; however, most of these cases could be detected by a mammography and possibly saving 150,000 lives (Price, et al., 1992). In addition, physicians have a significant influence on their health behaviors. According to research by Price et al., (1992) a questionnaire was given to identify triggers or cues to actions for women.

Ninety two percent of women would have a mammogram if their doctor told them to have one (Price, et al., 1992). Future studies should research the impact on mammography compliance, recommendations of a physician or significant other, or previous mammography history and experience.

Furthermore, there are differences between African American women and Caucasian women regarding health behaviors. African American women visits to the primary doctor are less likely to result in mammograms than for Caucasian women. African American women had a lower mammogram rate at each visit. For example, a single visit led to a mammogram for 7% of African Americans and 15% of Caucasians in Georgia (Burns et al., 1996). Moreover, African American women had a lower mammogram rate than Caucasian women in every state (Burns et al., 1996). Because of these findings, it is a concern because the 5-year breast cancer survival rate is lower for African American women than Caucasian women. In addition, African American women tend to delay treatment until the problem becomes serious as well as not utilize available services.

There is a gap between African American women and Caucasian women regarding health education and behavioral change. There has been very little attention given to the development of a culturally appropriate paradigm for health promotion in the African American community (Airhihenbuwa, 1992). According to Airhihenbuwa, culturally sensitive education and behavioral change models for health promotion in the African American communities tend to be the white experience (1992). There is a need for a model or working framework to guide the development disease prevention programs

and culturally appropriate health promotion targeted for the African American community. Foundations, research and programs must be based on the African American individual as a person independent of the Caucasian individual. In addition, it is not acceptable for an African American person to be recognized as an individual in comparison to a person. Properly understood, cultural beliefs and experiences can be used to advocate and promote health education and behavioral change in the African American community.

Attitudes

There is a fundamental lack of understanding about attitude and perception between the African American population and Caucasian population. There are obvious differences in communication style between African Americans and Caucasians, but the obvious styles are too complex to pinpoint. Specifically, health education programs, health promotions, and communication channels are effective to both populations in marketing preventive health practices (Williams, Best, Taylor, Gilbert, Wilson, Lindsay, Singer, and Gregg, 1990). However, how each population receives and perceives the information lies the unsolved mystery. There are several issues surrounding breast cancer for both African Americans and Caucasians, but the patterns of communication for these groups seems to be a mystery.

African Americans attitudes and perceptions regarding various issues about breast cancer seem to be culturally embedded. Exploratory research by Williams et al., (1997) talked about different themes in how African Americans view self-examination: 1) Doctors, nurses, and health care workers were types of women who performed the

procedure; 2) Women who felt good about themselves and breast performed self-exams; these women did not feel good about their bodies; 3) Other women were fearful to check their breast, they believed they might find a cancerous lump; 4) Some women did not know how to perform a self-breast examination, they were not sure of what to feel for or they were unclear about the procedure; 5) Lack of family support; 6) Low self-esteem; 7) Little societal support because most social marketing and advertising messages presented white women and preventive health issues.

These themes give researchers and the social work practitioners more insight into African American women thoughts and attitudes about self beast examines.

Perceptions

Caucasians are more likely to seek professional care when they feel they have health problems. African Americans are less likely to seek medical care, also, they tend to receive health care for various medical problems at later stages of diagnosis. Some African Americans tend to cope with medical problems then try to be proactive or preventive. Specifically, most African American women have many negative feelings associated with breast cancer. In fact, according to Williams et al., (1997) African American women's perceptions of breast cancer are: 1) not going to the doctor because they feel cancer would be found painful; 2) enduring an uncomfortable procedure; 3) unreliable results; 4) cancer is a disease that eats its victims; 5) cancer creates and feeds on poverty; 6) mental distress that accompanies cancer is as bad, or worse than the physical distress.

Furthermore, there were other disturbing perceptions held by African American women. They believed pap smears and mammograms were tests used to diagnose if you have cancer or the tests were to check for cancer. Instead, these tests were not perceived as interventions or to prevent breast cancer. According to Gregg (1991), African American women hypothesize that if cancer is caught in time, it could be stopped, however, they did consider screening as a prevention. Consequently, this attitude to "catch cancer in time" becomes impossible or useless to try to screen cancer. Other African American women believe cancer becomes real in the late stages, however, it is then fatal (1991). They believed cancer existed as bruises, scars, and sores before late stages of cancer (Gregg, 1991). In other words, they did not consider the importance of pap smears and mammograms as preventive methods of discovering precancerous conditions.

Typically, women are screened because their doctors refer them for screening. Women do not go for a screening because they are curious or interested in the procedure. Then the emphasis may need to fall on an increase with compliance with screening recommendation than modifying every African American women perception. Therefore, as social workers, one must find innovative ways to influence physicians and health providers to make more screening referrals. This influence would be a challenge, since some physicians have been reluctant to recommend screening mammography due to high cost and radiation hazard (Fulton et al., 1994). Surveys show that more than half of respondents received a recommendation from a medical provider (Fulton et al., 1994). There may be few recommendations because women and public show little demand for

breast cancer screening. Nevertheless, most studies show that women are willing to be persuaded by physicians to have a mammogram. Instead of only changing African American women's perceptions, social workers must encourage these women to receive mammograms as a primary intervention. This modification of doctor's behaviors should significantly increase breast cancer screenings. Moreover, health clinicians should have screening as a part of the patient's regular examination. In essence, the medical field has a lot of influence on altering attitudes and perceptions, which may stimulate a change in a patient's behaviors. Two area health clinics can initiate change: screenings need to explain as to prevent cancer not solely to discover cancer; and there must be an increase in screening for African American women. Last, there is a need for further exploration on the wide range of attitudes and perceptions among African American women and breast cancer.

Susceptibility

African American women who were surveyed for susceptibility provided some interesting findings. Some African American women believe they would be susceptible to breast cancer; some African American women believed that in comparison to other women the same age, 16% would develop breast cancer; and 9% believe they would develop breast cancer sometime in their lives (Williams et al., 1997). However, most of these African Americans believed, they needed a mammogram, although they practice healthy behaviors. There were 36% of African American women who did not want a mammogram. These women believed they did not need a mammogram because they had a physician check-up (Williams et al., 1997). Moreover, 44% of African American

women that did not want a mammogram did not think they would develop breast cancer (Williams, et al., 1997). In essence, these women believed they were not susceptible to breast cancer.

Severity

Unfortunately, these women had an unrealistic belief in how severe breast cancer could become according to Williams et al., (1997) 1) 55% disagreed that they would die if they had breast cancer; 2) 41% were uncertain; 3) 55% believed breast cancer would be that awful because they had faith in God; 4) 31% believed breast cancer would not affect their lives.

Moreover, many of these women did not know how certain behaviors could increase the risk of breast cancer such as smoking, a bump to the breast, not eating well, drinking too much alcohol, taking birth control pills, rough handling of the breasts, love bites, or too much stress. Last, African American women should be educated and made aware of the severity of breast cancer. Unfortunately, these beliefs determine their behavior, which affects how these women will practice health behaviors.

Barriers

Many African American women were surveyed to gather information about their personal barriers, eliminate obstacles, and implement benefits. Mostly African American women talked about several barriers such as: cost of mammograms, transportation, long wait, cost of medication, lack of doctor's referrals, appropriate treatment, mammograms are not necessary, and the fear of finding cancer. These barriers were common themes,

however, there is a significant relationship between income and education and women at risk.

Most research revealed African American women are in the lowest educational and income strata are less likely to participate in breast cancer early detection (Wells and Horm, 1992). Therefore, as education and income increases, the mortality rate decreases. Strikingly, there are differences between educational and income strata for African American women and Caucasian women. Consequently, due to lower socioeconomic status, African American women have less access to medical care, transportation, cost of medications and appropriate services.

Medical Benefits

Analyzing the barriers, interventions must be implemented to bring some medical benefits for women at risk. One benefit is a community-based clinical site. This community outreach effort is a source of referrals (Wells and Horm, 1992). Also, health workers from the sites are able to go into the community and visit facilities such as churches, beauty parlors, Laundromats, small businesses, libraries, grocery stores, and community agencies to recruit women for screening. Another benefit is education, physical examination, Papanicolaou (PAP) smear and mammography as a part of regular office visits. Next, by changing media messages to reflect African American role models, these changes would be more appropriate for the targeted population. Lastly, remove cost barriers for screenings and follow up services. If these screenings became free, there would be an increase of African American women participating and utilizing

these procedures. These medical benefits are attempts to deliver services to low-income Black women as a culturally appropriate intervention.

Overview of Major Theoretical Orientation

The purpose of this exploratory descriptive study is to evaluate if there are differences between African American women and Caucasian women regarding health seeking behaviors, perceptions, attitudes, susceptibility, severity, barriers, and medical benefits for breast cancer. The theory utilized for this thesis is derived from the Ecological Perspective. The Ecological Theory evaluates the nature of interactions and transactions between the individual or group, family, community and the greater environment (Hepworth, Rooney, and Larsen, 1997). In other words, it is the person-in-environment perspective and attempting to understand how people interact with their environment.

This model examines the person-in-environment and it views the behavior as being a series of interactions of people in different situations. It is the recognition of the impact of environmental factors upon human functioning, however, people are not solely reactors to environmental elements. On the contrary, people manipulate their environment by shaping and molding physical environment, people, groups, and institutions. Ecological Systems theory is concerned with various persons and systems reciprocally which influence each other. It is how individuals are engaged in constant transactions with other human beings and with other systems in the environment (Hepworth, Rooney, and Larsen, 1997). These other systems, described by Hepworth, (et al. (1997), are subsystems of the individual (biophysical, cognitive, emotional,

behavioral); interpersonal systems (child, parent, marital, family, kin, friends, etc.); and physical environmental (housing, weather, climate). The important concepts of the Ecological Systems Model for social work are habitat and niche. First, habitat is a person's physical and social settings. Hepworth et al. explains that humans tend to thrive when the habitat is rich with resources required for growth and development. However, when the habitat is deficient in crucial resources, physical, social, emotional development and ongoing functioning may be adversely affected explains Hepworth, et al. Therefore, if an individual has rich habitat of significant supportive social networks like friends, relatives, neighbors, work, church, the person is able to thrive and effectively cope with life stressors. The person may engage in drugs or alcohol, violent behaviors, or become extremely depressed.

Next, Hepworth et al. (1997), view niche as a status or role occupied by members of the community. It is a person trying to achieve a sense of identify and self-respect. Also, Germain suggests adaptation may be directed to changing oneself in order to meet environmental demands, or it may be directed to changing the environment so that physical and social settings will be more responsive to human needs, rights, goals, and capacities. It is the satisfaction of human needs and mastery of developmental task that require availability of adequate resources in the environment and positive transactions between persons and their environment (Hepworth et al., 1997). However, a person may not obtain their niche due to discrimination of race, ethnicity, gender, poverty, age disability, sexual identify, or religion. When this social injustice occurs that's when a social worker is politically active.

The goal of the social worker is to achieve adaptive fit between person and environment. Social work practitioner tries to assist people in utilizing ways to meet their needs. Unfortunately, when gaps in the environmental resources occur, limitations on individuals who need to utilize these resources, or dysfunctional transaction between individuals and environment systems block the fulfillment of human needs and lead to stress or impaired functions, a social worker must intervene (Hepworth et al., 1997). A social work practitioner must assess the source of the problem and determine the most effective and appropriate intervention. This is the first step in applying the Ecological System Model.

The researcher will apply the Ecological System Model as a theoretical framework to evaluate differences between African American women and Caucasian women regarding health seeking behaviors, perceptions, attitudes, susceptibility, severity, barriers, and medical benefits for breast cancer. The research will discuss the Ecological Perspective by using habitat and niche as a foundation to circumstantiate the differences between African American women and Caucasian women regarding breast cancer due to the conditions of poverty and racism.

According to the habitat concept, humans tend to thrive when environment is rich with resources required for growth and development and social networks are many and strong. Typically, this habitat, is the normal life style for many Caucasian women. Usually, they are able to obtain well paying jobs through which many other benefits are acquired. A well paying job provides sufficient financial funds, medical benefits, employee benefits, childcare facilities, status, power, privileges, and self-respect.

Therefore, Caucasian women are able to find their niche in society due to opportunities. Therefore, Caucasian women's normal lifestyle is secured with a well established habitat and valuable niche in society. In essence, habitat and niche for Caucasian women as individuals and as a group are strongly supported and positively reinforced. It is a successful flowing cycle for Caucasian women because the lifestyle is supported and reinforced by society and resources. Lifestyles of Caucasian women are supported by society and the privilege of rich resources which is to maintain and reinforce their mental, physical, and emotional well-being. Therefore, when the disease of breast cancer enters the lifestyle of Caucasian women, they are already prepared on each level. Caucasian women are prepared and able to confront breast cancer because they have rich resources and society supports, in order to improve their subsystems, equip their physical environment, and utilize strong interpersonal systems. Therefore, Caucasian women are able to shape and mold their environment at will due to society's support and rich resources.

According to this Ecological Perspective, Caucasian women benefit in many ways. Typically, Caucasian women have rich resources within their environment and they successfully find a self-respected niche in society. Rarely, Caucasian women confront racism or poverty. Usually, society value and respect Caucasian women more than African American women. As a result, Caucasian women are able to somewhat self-actualize the Hierarchy of Need and accomplishing tasks of the psychosocial stages.

Therefore, due to the fact that Caucasian women are treated differently, they will respond culturally different. Consequently, due to respect and value they receive, they

develop high self esteem. The studies have shown that when women have high self esteem they are more willing to do self-examines. To take this step further, Caucasian women will perform more self-examines and they most likely will detect a lump. Since Caucasian women feel trust and security with society, they will go to seek medical help. As a result, these behaviors and actions contribute to lower deaths of breast cancer for Caucasian women. Hence, giving Caucasian women higher survival rate of breast cancer as a whole. In essence, all these factors support why there are differences between African American women and Caucasian women regarding breast cancer.

There is a unique difference in lifestyle between Caucasian women and African American women. The unique lifestyles are different according to each habitat and niche. Unfortunately, most African American women deal with many deficiencies in their habitat. Some African American women have deficiencies in crucial resources, social networks, physical, and emotional development. In other words, the lifestyle for African American consist of poor subsystems, weak interpersonal systems, and inadequate living environment. The habitat for African American women do not sufficiently meet their needs or provide stable well-being mentally, physically, and emotionally. When one battles poverty, the environment lacks resources to stimulate growth and development.

The next level is for African American women to find their niche in society. Since the habitats are deficient for many African American women, they are at a disadvantage for successfully finding their niche in society. Beside battling poverty in their environment, they fight racism in society. Usually due to racism, African

Americans are not able to obtain a well paying job with acquired benefits. Some African American women must take low paying jobs or part-time jobs to survive. Without a well paying job, African American women can't obtain sufficient money for bills and childcare, medical benefits, employee benefits, status, job promotion, privileges, or respect for employers. Due to discrimination and unequal opportunities, it is difficult for African American women to find their niche in society. In essence, habitat and niche for African American women as individuals and as a group are not supported and negatively reinforced by society. It is a negative cycle for African American women gushing with poverty and racism. Lifestyles of African American women are supported with societal racism and environment poverty which may cause a lack of growth mentally, physically, and emotionally. Therefore, breast cancer enters the lifestyle of African American women, they may not be prepared on different levels. Some African American women are not prepared and able to confront breast cancer because of deficient resources, poor subsystems, inadequate physical environments, and weak interpersonal systems. Also, many African American women may respond to breast cancer in a dysfunctional way. At times, some African American women are unable and not equipped to shape and manipulate their environment at will due poverty and racism.

Usually, African American women have limited resources within their habitat and they rarely receive well deserved niche in society. Daily, African American women fight racism and poverty as naturally as one breaths air. African American women are not valued and respected like Caucasian women. Consequently, these problems can interfere

with African American women actualizing the Hierarchy of Needs or becoming stuck within a psychosocial stage.

African American women can somewhat utilize Maslow's Hierarchy of Needs, however, Strengths Perspective is a more appropriate model for African American women. Caucasian women can benefit and somewhat actualize the Hierarchy of Needs because its purpose was solely designed for European thinking and lifestyle by a Caucasian theorist. On the other hand, Strengths Perspective was developed to describe and accommodate African American people. Having a Afrocentric foundation, the Strength Perspective honors and values African American women as a whole.

Strengths Perspective is more appropriate for African American women for many reasons. Given African American history, African American women are of courage, pride, and strength. As a whole, they are able to take on multiple roles, many times effectively, other times functioning can be adversely affected. African American women live by the expression, 'find a way or make a way.' They gain their self-respect from who they are as an individual and as a group. They take pride in children, families, and friends. Also, they are creative and inventive. They use family remedies, herbal pills, and prayers. Although the living environment may lack resources, African American women do a lot with very little. The homes will be clean, decorated with Afrocentric items, and wall hangings of African American leaders. What can't be afforded, African American women will borrow, improvise or create. Last, whatever African American women lack in interpersonal systems, they form fictive kin or neighbor network. Most importantly, if they are alone, they rely on spiritual guidance. In essence, African

American women may not receive the respect and value that Caucasian women get, but they learn to value and respect themselves. African American women have found their power and strength within their inner being. This is how African American women empower themselves. This strength is genuine as opposed to a false sense of self offered by society.

African American women may believe it is not important for them to perform self-examines due to advertisement and how they are not valued by society. Since some African American women will less likely perform self-examines, they will unlikely detect a lump in their breast. Additionally, these African American women will not see a need to seek medical help because of no detection and do to the mistrust of society. As a result, these actions and responses will contribute to a higher death rate of breast cancer for African American women. As a group, African American women have a low survival rate for breast cancer. In conclusion, poverty, lack of resources and racism are some of the causes of why there are differences between African American women and Caucasian women regarding breast cancer.

Statement Of The Hypothesis

There will be a significant statistical difference between African American women and Caucasian women: health seeking behaviors, perception, attitudes, susceptibility, severity, barriers, and medical benefits regarding breast cancer.

Definition Of Variables

Breast cancer is body tissue that is destroyed by the growth of abnormal cells (Weisbrod, 1996). In other words, it's one cell ruining it for the other cells. The goals for healthy cells are to grow, divide, and replace old cells that form the tissue of the body. This keeps the body functioning properly and orderly. However, the reproductions of some cells lose the ability to control growth. Hence, the reproductions of these cells become fast growing and chaotic in function. Moreover, breast cancer can be either malignant or benign. Malignant tumors are cancerous that usually invade and destroy other healthy tissues and organs nearby. Consequently, tumors develop because there is too much tissue. However, benign tumors are not cancerous.

Typically, histology examination of tissue is a definite and accurate diagnosis of breast cancer (Weisbrod, 1996). One must microscopically examine the cell structure of tissue and determine if the cells are cancerous. Early diagnosis can be detected by several techniques such as palpation, mammography, ultrasonography, computerized topography, aspiration, and biopsy (Weisbrod, 1996). The physical signs which may signify breast cancer are painful swelling; lump in the underarm area; discrete lump; nipple retraction; nipple bleeding; discharge; and crusting; and skin puckering (Weisbrod, 1996). In addition, the patient has the option to participate in radiation and chemotherapy. Unfortunately, there is physical sickness after treatment. The side effects of treatment are vomiting, weakness, memory loss, hair loss, depression, disoriented, discoloration of the skin, and loss of appetite and memory. In essence, there are many ways to detect and diagnose breast cancer.

The variables that will be used in this study are: Independent variables (African American women and Caucasian women) and dependent variables (health seeking behaviors, perceptions, attitudes, susceptibility, severity, barriers, and medical benefits) Fulton et al., define the variables as follows: 1) **Health Seeking Behaviors**: It is a screening behavior from which time since the last physical breast examination and time since the last screening mammogram; 2) **Perceptions**: Perceived susceptibility to breast cancer and perceived seriousness of breast cancer; 3) **Attitude**: A mental position; the feeling one has for oneself; 4) **Susceptibility**: Capable of admitting any change of influence; impressible; sensitive; 5) **Severity**: Strict; stern; hard; not fancy; extremely painful; intense; 6) **Barriers**: A structure that restricts or bars entrance and 7) **Medical Benefits**: Benefits consisting of perceived effectiveness of mammography and barriers consisting of perceived safety of mammography and perceived comfort of mammography.

CHAPTER THREE

METHODOLOGY

Research Design

An exploratory research design was used in this study. This comparative analysis was used to explore if there is a significant statistical relationship between African American women and Caucasian women with: perceptions health seeking behaviors attitudes, susceptibility, severity, barriers, and medical benefits regarding breast cancer.

Since there are few studies and little known involving this topic, an exploratory design was appropriate for this research. Emphasis was placed on developing the hypothesis and identifying important variables more than testing or precise measurements. (Weschsler et. al., 1981).

Setting

The study was conducted at two churches; Liveoak Baptist Church located in College Park and Forest Park Church of Christ located in Forest Park.

Sample Population

The population in this study consisted of 30 women. The sample consisted of 15 African American women and 15 Caucasian women who were between the ages of 35-55, who agreed to participate in this study. Nonprobability sampling was used to select

the population for the study. Since nonprobability sampling was used, it did not provide an equal chance to include all members of the population (Wechsler, et. al., 1981). Therefore, this technique could not be an acceptable representative sample and could not be generalized to the population (Wechsler, et al., 1981). However, the researcher used this sampling for easy access to both populations. The rationale for selecting nonprobability sampling is to be able to select subjects in a specific location at a particular time.

Data Collection Procedure

The researcher contacted the minister of each church to request permission for member to participate in the study. Originally, there were forty-four in the group, however, while briefing the participants, fourteen of the women decided not to participate. The thirty remaining women decided to participate. Confidentiality and anonymity was explained. Each participant was advised not to put any identifying marks on their questionnaire. The researcher gave each member present that day a questionnaire. This questionnaire was modified and taken from different instrumentions according to how the variables were chosen to be analyzed within the hypothesis.

The researcher contacted the secretary of each church at which the researcher was given an appointment to see the pastor. At the appointment, the pastor gave the researcher verbal and written permission to administer the questionnaire to the Bible study members. A week before the questionnaires were given to the groups, the secretary made an announcement that an anonymous questionnaire would be given at the next

Bible study meeting. The day the questionnaire was given, the researcher explained before the test that it was completely anonymous, confidential, and strictly voluntary. The test took approximately 30-45 minutes to complete. The test consisted of sixty-one questions. The subtests included seven demographic questions; twelve health seeking behaviors questions; eighteen perception questions; four attitude questions; five susceptibility questions; seven severity questions; seven barriers questions; and six medical benefit questions.

Instrumentation

The breast cancer questionnaire consists of demographics and eight subtests. The rationale for this type of questionnaire was to have much information about breast cancer to fill in some missing gaps of research and to stimulate further studies in breast cancer. The questionnaire consists of sixty-one questions.

The seven subtests were borrowed from the following instruments: East/West Breast Express Questionnaire (Health Seeking Behavior); A Study Guided By The Health Belief Model Of The Predictors of Breast Cancer Screening Of Women Ages 40 And Older (Perceptions); Using Focus Group Methodology To Develop Breast Cancer Screening Programs That Recruit African American Women (Attitudes); and Urban Black Women's Perceptions Of Breast Cancer And Mammography. (Susceptibility, Severity, Barriers, and Medical Benefits). The Health Seeking Behavior subtest contained questions of demographics. The instrument measured if and how often women received medical attention for breast exams. The Perception substest measured women's

use of breast cancer screening and to investigate potential predictors of use. The Attitude subtest measured knowledge, assess the attitudes, and change behaviors of African American women. Last, the susceptibility, severity, barriers, and medical benefits substest measured differences in perceptions of breast cancer and mammography between African American women who wanted a mammogram and those who did not want a mammogram. Next, the researcher could not generalize to the population because the tool was not tested for validity and reliability.

Data Analysis

For the purpose of this study, Statistical Package For The Social Science 7.5 (SPSS) was utilized for the data analysis. An independent sample t-Test was selected to determine the differences between the variables stated within the hypothesis. The level of significance was set at .05. Additionally, cross-tabulation was employed to present frequency and percent distribution for demographic variables by race.

CHAPTER FOUR

PRESENTATION OF RESULTS

The data collected in this study provided a profile of thirty African American and Caucasian women who participated in this study. Information in this chapter has been arranged in two sections: 1) demographic profile and 2) an analysis of the hypothesis under study.

Table 1

Cross Tabulation Of Race By Age
N=30

Race	18-29	30-39	40-49	50-59	60-69
Black	4 (26.7%)	5 (33.3%)	5 (33.3%)	1 (6.7%)	0
White	2 (13.3%)	3 (20.0%)	4 (26.7%)	5 (33.3%)	1 (6.7%)
Total	**6**	**8**	**9**	**6**	**1**

The above table shows four (26.7%) Black women and two (13.3) White women between the age of 18-29. Five (33.3%) Black women and three (20.0%) White women were found to be between 30-39. Similarly, five (33.3%) Black women and four (26.7%) White women were between the age of 40-49, while the remaining one (6.7%) Black women, five (33.3%) White women were between the age of 50-59, and one (6.7%) was White.

Table 2

Cross Tabulation Of Race By Ethnic Background
N=30

Ethnic Background	African American	Caucasian
Black	15	15
White	15	15
Total	**30**	**30**

There were fifteen (50.0%) African American women and fifteen (50.0%) Caucasian women in this study.

Table 3

Cross Tabulation Of Race By Education
N=30

Education	Completed High	Technical Vocational	Some College	Completed College	Graduate School	Doctoral
White	4 (26.7%)	2 (13.3%)	7 (46.7)	2 (13.3%)	0	0
Black	0	2 (13.3%)	7 (46.7)	5 (33.3%)	1 (6.7%)	0
Total	**4**	**4**	**14**	**7**	**1**	**0**

The above table shows four (26.7%) White women graduated from high school. Two (13.3%) Black women and two (13.3%) White women graduated from technical/vocational school. Seven (33.3%) Black women and seven (33.3%) White women attended college. Five (33.3%) Black women and two (13.3%) White women completed college. While the remaining one (6.7%) Black women completed graduate school.

Table 4

Cross Tabulation Of Race By Martial Status
N=30

Marital Status	Single	Married	Divorced	Separated	Widow
Black	2 (13.3%)	10 (66.7%)	2 (13.3%)	0	1 (6.7%)
White	1 (3.7%)	11 (73.3%)	1 (6.7%)	0	1 (6.7%)
Total	**4**	**21**	**3**	**0**	**2**

The above table shows two (13.3%) Black women and one (6.7%) White women were single. Ten (66.7%) Black women and eleven (73.3%) White women were married. Next, two (13.3%) Black women and one (6.7%) White women were divorced. The remaining one Black women (6.7%) and one (6.7%) White woman was widowed.

Table 5

Cross Tabulation Of Race By Employment
N=30

Employment Status	Employed	Unemployed	Homemaker	Student	Other
Black	12 (80.0%)	1 (6.7%)	2 (13.3%)	0	0
White	7 (46.7%)	0	7 (46.7%)	0	1
Total	**19**	**1**	**9**	**0**	**1**

The above table shows twelve (80.0%) Black women and seven (46.7%) White women were employed. One (6.7%) Black woman was unemployed. Next, two (13.3%) Black women and seven (46.7%) White women were homemakers.

Table 6

Cross Tabulation Of Race By Insurance
N=30

Insurance	Insured	Uninsured	Medicare	Medicaid	Medicare/ Medicaid	Other
Black	14 (93.3%)	1 (6.7%)	0	0	0	0
White	12 (80.0%)	1 (6.7%)	2 (13.3%)	0	0	0
Total	**26**	**2**	**2**	**0**	**0**	**0**

The above table shows fourteen (93.3%) Black women and twelve (80.0%) White women were insured. One (6.7%) Black woman and one (6.7%) White woman were uninsured. While the remaining two (13.3%) White women received Medicare.

Table 7

Cross Tabulation Of Race By Income
N=30

Income	Black	White	Total
Less than 5,000	1 (6.7%)	1 (6.7%)	**2**
5,000-10,000	0	1 (6.7%)	**1**
10,000-20,000	1 (6.7%)	2 (13.3%)	**3**
20,000-30,000	6 (40.0%)	3 (20.0%)	**9**
30,000-40,000	5 (33.3%)	3 (20.0%)	**8**
40,000-50,000	1 (6.7%)	3 (20.0%)	**4**
60,000-70,000	1 (6.7%)	1 (6.7%)	**2**
90,000-More	0	1 (6.7%)	**1**

The above table shows one (6.7%) Black woman and one (6.7%) White woman received an income less than 5,000. One White woman received between 5,000-10,000. Next, one (6.7%) Black woman and two (13.3%) White women received an income between 10,000-20,000. While six (40.0%) Black women, three (20.0%) White women

received an income between 20,000-30,000. Next, five (33.3%) Black women and three (20.0%) White women received an income between 30,000-40,000. Also, one (6.7%) Black woman and three (20.0%) White women received and income between 40,000-50,000. There was one (6.7%) Black and one (6.7%) White woman received an income between 60,000-70,000. Last, one White woman received an income of 90,000 and more.

Hypothesis Results

An independent sample t-Test analysis is used for the following section which provides the results of the hypothesis under study.

Ha: There will be a statistically significant difference between African American women and Caucasian women: health seeking behavior, perceptions, attitudes, susceptibility, severity, barriers, and medical benefits regarding breast cancer.

Table 8

Cross Tabulation Of Race By Health Seeking Behavior
N=30

Race	Yes	No	Not Sure
Black	15 (100.0%)	0	0
White	13 (86.7%)	2 (13.3%)	0
Total	**28**	**2**	**0**

The above table shows fifteen (100.0%) Black women and thirteen (86.7%) White women had a clinical breast exam, that is healthcare provider ever examined their breast.

Two (13.3%) White women did not have a clinical breast exam, that is healthcare provider ever examined their breast.

Table 9: t-Test For Health Seeking Behaviors

(Analysis of the t-Test between Black and White Female Participation)

Group	Mean	S.D.	T-Value	P.
Black	1.466	.7432		
			1.969	.059
White	1.066	.2582		

Data presented in Table 9 are the results from the one-way analysis of variance between Black and White female participants. Black women mean score was 1.466 (S.D. = .732); and White women mean score was 1.066 (S.D. = .2582). Both scores signifying a T-Value of 1.969 and P. of .059. There was no statistically significant difference between African American women and Caucasian women with reference to Health Seeking Behavior.

Table 10

Cross Tabulation Of Race By What Are Your Chances Of Getting Breast Cancer In The Next 10 Years?

Perceptions
N=30

Race	Excellent	Good	Fair	Poor
Black	1 (6.7%)	4 (26.7%)	5 (33.3%)	5 (33.3%)
White	1 (6.7%)	5 (33.3%)	8 (53.3%)	1 (6.17%)
Total	**2**	**9**	**13**	**6**

The above table shows one (6.7%) Black woman and one (6.7%) White woman had an excellent chance of getting breast cancer in the next ten years. Four (26.7%) Black women and five (33.3%) White women thought they had a good chance of getting breast cancer in the next ten years. Next, five (33.3%) Black women and one (6.7%) White woman thought they had a poor chance of getting breast cancer in the next ten years.

Table 11

t-Test For What Are Your Chances Of Getting Breast Cancer In The Next 10 Years?

(Perceptions)

(Analysis Of The t-Test between Black and White Female Participants)

Group	Mean	S.D.	T-Value	P.
Black	2.9333	.9612		
			1.066	.296
White	2.6000			

Data presented in Table 11 are the results from the one-way analysis of variance between Black and White female participants. Black women mean score was 2.9333 (S.D. = .962); and White women mean score was 2.6000 (S.D. = .7368). Both scores signifying a T-Value of 1.066 and P. of .296. There was no statistical significant difference between African American women and Caucasian women with reference to Perceptions.

Table 12

Cross Tabulation Of Race By Being Happy With My Life
N=30

Race	1.00-4.00	5.00-8.00	9.00-12.00	13.00-16.00
Black	13 (86.7%)	2 (13.3%)	1 (6.7%)	0
White	10 (66.7%)	2 (13.3%)	1 (6.7%)	3 (20.0%)
Total	**23**	**4**	**2**	**3**

The above table shows thirteen (86.7%) Black women rated being happy with their life as being the most important priority. Two (13.3%) Black women rated being happy with their life as being the second most important priority. Next, one Black woman (6.7%) and one (6.7%) White woman were rated being happy with their life as being the third most important priority. While no Black women and three (20.0%) White women rated being happy with their life as being the forth most important priority. However, ten (66.7%) White women rated being happy with their life as being the most important priority. Also, two (13.3%) White women rated being happy with their life as being the second important priority. Moreover, one (6.7%) White woman rated being happy with their as being the third important priority.

Table 13

t-Test For Being Happy With My Life

(Analysis of the t-Test between Black and White Female Participants)

Group	Mean	S.D.	T-Value	P.
Black	3.0667	1.7512		
			-1.385	.177
White	4.8667	4.7188		

Data presented in Table 13 are the results from the one-way analysis of variance between Black and White female participants. Black women mean score was 3.0667 (S.D. = 1.7512); and White women mean score was 4.8667 (S.D. = 4.7188). Both scores signifying a T-Value of -1.385 and P. of .177. There was no statistical significant difference between African American women and Caucasian women with reference to Perceptions.

Table 14

Cross Tabulation Of Race By Attitudes
N=30

Race	Yes	No	Not Sure
Black	11 (73,3%)	3 (20.0%)	1 (6.7%)
White	11 (73.3%)	2 (13.3%)	2 (13.3%)
Total	**28**	**2**	**2**

The above table shows eleven (73.3%) Black women and eleven (73.3%) White women thought mammograms were uncomfortable. Three (20.0%) Black women and two (13.3%) White women thought mammograms were uncomfortable. Next, one

(6.7%) Black woman and two (%) White women were not sure if mammograms were uncomfortable.

Table 15

t-Test For Attitudes

(Analysis of the t-Test between Black and White Female Participants)

Group	Mean	S.D.	T-Value	P.
Black	1.3333	.6172		
			-.269	.790
White	1.4000	.7368		

Data presented in Table 15 are the results from the one-way analysis of variance between Black and White female participants. Black women mean score was 1.3333 (S.D. = .6172); and White women mean score was 1.4000 (S.D. = .7368). Both scores signifying a T-Value of -.260 and P. of .790. There was no statistically significant difference between African American women and Caucasian women with reference to Attitudes.

Table 16

Cross Tabulation Of Race By Susceptibility
(N=30)

Race	Yes	No	Not Sure
Black	9 (60.0%)	3 (20.0%)	3 (20.0%)
White	8 (53.3%)	3 (20.0%)	4 (26.7%)
Total	**17**	**6**	**7**

The above table shows nine (60.0%) Black women and eight (53.3%) White women thought compared to others their age, their likelihood of developing breast cancer is a possibility. Three (20.0%) Black women and three (20.0%) White women disagreed that compared to others their age, their likelihood of developing breast cancer is a possibility. Next, three (20.0%) Black women and four (26.7%) White women were not certain if compared to others their age, their likelihood of developing breast cancer is a possibility. While the remaining one (6.7%) Black woman and one (6.7%) White women did not answer the question.

Table 17

t-Test For Susceptibility

(Analysis of the t-Test between Black and White Female Participants)

Group	Mean	S.D.	T-Value	P.
Black	1.6000	.8281		
			-.648	.522
White	2.5333	3.2921		

Data presented in Table 17 are the results from the one-way analysis of variance between Black and White female participants. Black women mean score was (S.D. = .8281); and White women mean score was 2.5333 (S.D. = 3.2921). Both scores signifying a T-Value of -.648 and P. of .522. There was no statistically significant difference between African American women and Caucasian women with reference to Susceptibility.

Table 18

Cross Tabulation Of Race By Severity
N=30

Race	Yes	No	Not Sure
Black	6 (40.0%)	5 (33.3%)	4.(26.7%)
White	11 (73.3%)	4 (26.7%)	0
Total	**17**	**9**	**4**

The above table shows six (40.0%) Black women and eleven (73.3%) White women thought their life would change. While five (33.3%) Black women and four (26.7%) White women disagreed that their life would change. While the remaining four (26.7%) Black women were not certain.

Table 19

t-Test For Severity

(Analysis of the t-Test between Black and White Female Participants)

Group	Mean	S.D.	T-Value	P.
Black	2.0000	.5345		
			2.443	.021
White	1.8000	.4140		

Data presented in Table 19 are the results from the one-way analysis of variance between Black and White female participants. Black women mean score was (S.D. = 2.000); and White women mean score was 2.000 (S.D. = 1.800). Both scores signifying a T-Value of 2.443 and P. of .021. There was no statistically significant difference between African American women and Caucasian women with reference to Barriers.

Table 20

Cross Tabulation Of Race By Barriers
N=30

Race	Yes	No	Not Sure
Black	1 (6.7%)	14 (93.3%)	0
White	2 (13.3%)	13 (86.7%)	0
Total	**3**	**27**	**0**

The above table shows one (6.7%) Black women and two (13.3%) White women agree that not having time would keep me from having a mammogram. Fourteen (93.3%) Black women and thirteen (86.7%) White women disagreed that not having time would keep me from having a mammogram.

Table 21

t-Test For Barriers

(Analysis of the t-Test between Black and White Female Participants)

Group	Mean	S.D.	T-Value	P.
Black	2.0000	.0000		
			.582	.559
White	2.0000	.5345		

Data presented in Table 21 are the results from the one-way analysis of variance between Black and White female participants. Black women mean score was (S.D. = .0000); and White women mean score was 2.000 (S.D. = .5345). Both scores signifying a T-Value of .582 and P. of .559. There was no statistically significant difference between African American women and Caucasian women with reference to Barriers.

Table 22

Cross Tabulation Of Race By Medical Benefits
N=30

Race	Yes	No	Not Sure
Black	15 (100.0%)	0	0
White	13 (86.7%)	2 (13.3%)	0
Total	**28**	**2**	**0**

The above table shows fifteen (100.0%) Black women and thirteen (86.7%) White women would want a mammogram to find out if they were O.K. While the remaining two (13.3%) White women disagreed with wanting a mammogram to find out if they were O.K.

Table 23

t-Test For Medical Benefits

(Analysis of the t-Test between Black and White Female Participants)

Group	Mean	S.D.	T-Value	P.
Black	1.0000	.0000		
			-1.468	.153
White	1.1333	.3519		

Data presented in Table 23 are the results from the one-way analysis of variance between Black and White female participants. Black women mean score was 1.000 (S.D. = .0000)l and White women mean score was 1.1333 (S.D. = .3519). Both scores signifying a T-Value of -1.468 and P. of .153. There was no statistically significance difference between African American women and Caucasian women with reference to Medical Benefits.

Table 24

Cross Tabulation Of Race By: Are You Able To Pay For A Mammogram?
N=30

Race	Yes	No	Not Sure
Black	10 (66.7%)	3 (20.0%)	2 (13.3%)
White	14 (93.3%)	1 (6.7%)	0
Total	**24**	**4**	**2**

There were ten (66.7%) Black women able to pay for a mammogram and three (20.0%) Black women were not able to pay for a mammogram. There were fourteen (93.3%) White women were able to pay for a mammogram and one (6.7%) White women was not able to pay for a mammogram.

Table 25

t-Test For Paying For Mammogram

(Analysis of the t-Test between Black and White Female Participants)

Group	Mean	S.D.	T-Value	P.
Black	1.466	.7432		
			1.969	.059
White	1.066	.2582		

Data presented in Table 25 are the results from the one-way analysis of variance between Black and White female participants. Black women mean score was 1.466 (S.D. = .7432); and White women mean score was 1.066 (S.D. = .2582). Both scores signifying a T-Value of 1.969 and P. of .059. There is a statistical difference between Black women and White women with reference to the question: Are you able to pay for a mammogram.

CHAPTER FIVE

SUMMARY AND CONCLUSION

This summary and conclusion will bring an overview of this study and it will discuss further options. This chapter will summarize the following: theoretical framework that supported the researcher's hypothesis, current research, Strength model, limitations, community base sites.

According to the Ecological Perspective, Hepworth et al. believed the ecological model emphasized various persons and systems reciprocally influence each other and how the habitat and niche has an impact on an individual's life psychosocial . This theoretical framework was used as the foundation to support the researcher's hypothesis. However, the hypothesis was not supported by the statistical data. Therefore, there were no statistical significances in reference to African American women and Caucasian: health seeking behaviors, perceptions, attitudes, susceptibility, severity, barriers, and medical benefits regarding breast cancer.

Current research shows that Caucasian women have a higher incident rate of breast cancer than African American women. However, due to education, income, racism, and a lack of referrals are some of the causes that contribute to the low survival rate of breast cancer for African Americans. There are several interventions that can help increase the survivor rate of breast cancer for African American women. The focus must

start with a culturally appropriate psychosocial and medical model for African American women in regarding breast cancer.

The Strength Model is consistent with social workers placing emphasis on helping people help themselves which fosters self-determination. This perspective brings forth improvement which impacts the overall quality of life of persons served. These models look at the clients strengths more than pathologies. Also, individuals with mental illness still have the capacity to learn, grow, and change; the relationship is essential and crucial between client and practitioner; the clients' interventions are predicted by their self-determination. Consequently preferred intervention would be outreach. Community should be utilized for resources and not red tape barriers.

The study indicated that if African American women had access to appropriate resources, they would utilize breast cancer screenings. More specifically, if doctors refer African American women for mammograms, these women would most likely go because the doctor made the referral. Also, the study discussed that if the cost of breast cancer screenings were eliminated, it would close the gap of the survivor rate between African American women and Caucasian women. Although the statistics did not support the hypothesis, current research had significant relevance for this study.

Limitations Of The Study

There were a variety of professional concerns about this study. For example, the sample population was a small and homogenous group of participants. The sample was not large enough to generalize the results to outside populations. The design may have

impacted the results.

The women that participated in this study were not representative of the entire population at both churches: Liveoak Baptist Church and Forest Park Church of Christ. This study was limited to African American women and Caucasian women between ages of eighteen and sixty-nine. The women selected to participate in this study were not representative of all the women lower socioeconomic community only as active church members. The sample for this study was limited to thirty respondents. The questionnaire for this study was limited to health seeking behaviors, perception, attitudes, susceptibility, severity, barriers, medical benefits for breast cancer. The demographics for this study were limited to age, female, gender, African American women, Caucasian women, education, grade level, marital status, employment status, insurance, and income.

Next, the researcher had a difficult time acquiring specific material from social work journals. The majority of articles in social journals discussed psychosocial issues, breast cancer for African American women and Caucasian women separately, or social worker roles in health care. Due to the limitation of information for the hypothesis, the researcher had to utilize other professional journals to complete this thesis. Unfortunately, the researcher discovered that the majority of studies have been conducted by researchers from other professionals and disciplines. These limitations for this study are valid reasons why there is an extensive need for more research in social work journals regarding breast cancer.

Regarding health care-related psychosocial research, the vital interests for social work are basic psychosocial research, psychosocial treatment and intervention research,

and health services research. As the policymakers's concerns are cost, quality, and outcomes of health care, the social worker must increase the empirical foundation of its practice and develop more research-based knowledge to bring to the table. Also, Rosalie Kane (1982) predicted that psychosocial research would influence health care decision making, that researchers from other professions and disciplines would conduct basic and applied psychosocial research, and the social workers would have to live with the results. Unfortunately, research by others somewhat fail to address problems and services of particular concern to social workers (Ell, 1996). Therefore, social workers must work to improve social work services, delivery of psychosocial services, and increase research studies. Emphasis must be given to gaps in the existing research on basic psychosocial research, psychosocial treatment and intervention research, and health services research.

There are several care issues faced by the breast cancer client regarding community-based sites. Initially, the goals of community-based facilities are to receive active participation of people in the community, such as local constituencies, and incorporate strategies of interventions (Taylor, Taplin and Urban, 1996). Moreover, it is a way to promote preventive behaviors and preventive care within the community. Are community-based organizations fulfilling these qualifications and meeting the needs of breast cancer clients? Aside from these questions, American women are dying from breast cancer; which is the second leading cause of death from cancer (Forte, 1995). The mortality rate is higher for African American women than Caucasian women, although, breast cancer incidence reported are lower among African American women. Due to these statistics, community-based organizations have an urgent need to reach this

population. However, there are barriers which block interaction between community-based sites and breast cancer clients. These barriers are a lack of physician referrals for mammogram, not enough community-based facilities, accessibility, cost, uninsured and underinsured, and lack of education and knowledge available to the client. Therefore, the community-based organizations must go one step further to reach these abandoned clients, which are African American women. The need to reach African American women is a necessity because Caucasian women are accounted for. Unable to reach African American women through conventional means, the community-based organizations must meet the client where the client is. As a result, the sites have gone to local community centers, clinics, churches, Laundromats, grocery stores, and beauty salons (Forte, 1995). This direct approach is helping make an impact on African American women. Importantly, community-based care is one innovative intervention, which is making an effective change and impact among the African American community.

These barriers are a lack of physician referrals or mammogram, not enough community-based facilities, accessibility, cost, uninsured and underinsured, and lack of education and knowledge available to the client. Therefore, the community-based organizations must go one step further to reach these abandoned clients, which are African American women. Unable to reach African American women through conventional means, the community-based organizations must meet the client where the client is. As a result, the sites have gone to local community centers, clinics, churches, Laundromats, grocery stores, and beauty salons (Forte, 1995). This direct approach is

churches, Laundromats, grocery stores, and beauty salons (Forte, 1995). This direct approach is helping make an impact on African American. Importantly, community based care is one innovative intervention which is seeking an effective change and impact among the African American community.

There are several agencies and professionals engaged in the treatment of breast cancer. The agencies consist of hospitals and cancer committees, medical clinics, National Cancer Institute (NCI), Cancer Prevention Research Unit, mobile mammography van, community centers, Drew-Meharry-Morehouse Cancer Consortium, to name a few (Taylor, et al., 1996). Typically, the professionals involved in combating breast cancer are primary care physicians, oncologist, radiologists, surgeons, counselors, and social workers. If these agencies and professionals worked as a collective front, elimination of breast cancer is possible.

Suggestions toward future studies are a call for a significant increase in social work research and more social workers contributing to the growing body of health-related psychosocial and service research. The majority of studies must be conducted by the social work profession not other disciplines. It will take clinical practice, education, and political action to further social workers contribution to the development of empirically based knowledge; biopsychosocial assessments; more mammography referrals; and to formulate policy regarding breast cancer. Social work efforts to impact and shape health care delivery will be through empirical data which is also consistent with the profession's basic goals and values. Ell (1996) describes how history will record this time as one during which social work accepted the challenge to increase its application of and

contribution to its scientific knowledge base to improve the health and quality of life of the nation, including its most vulnerable people.

The researcher's recommendations for practice is for social workers to lead workshops concerning cultural beliefs and lifestyles of African American women for doctors for and other professionals. Social workers could appeal to the medical arena by showing facts, studies, and how cost-effective interventions could be implemented. Furthermore, social workers could have fund-raisers, doctors, celebrities, and survivors of breast cancer give speeches. Last, medical teams and social workers could intervene within the African American communities to educate, advocate, perform breast exams, and make referrals for mammograms. In essence, the direction of research is for social work to actively take part on all levels: micro, mezzo, and macro.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

This study does not show any significant statistical evidence that African American women and Caucasian women: health seeking behaviors, perception, attitudes, susceptibility, severity, barriers, and medical benefits regarding breast cancer. This study demonstrated the importance of women, medical professionals, manage-care, and social workers to become aware of various factors that hinder breast cancer screenings.

Social workers who work with women, communities and other professionals can be a vital resource in educating and advocating appropriate interventions for increasing the survival rate of breast cancer for African American women. Most importantly, this study is important to social workers because they will be able to influence and persuade other professionals to increase breast cancer screenings. If social workers are knowledgeable of the factors that contribute to low survival rate of breast cancer for African American women, they can make recommendations to increase resources and referrals for breast cancer screenings.

Regarding health care, the history and future of social workers have had and have a place in acute, ambulatory, and long-term care as well as bringing pertinent skills to manage care. Next, our knowledge and communication are affected by the advancement of medical and computer technology. Consequently, due to the explosion of medical technology, women with breast cancer as well as long-term patients with chronic

illnesses are increasing, which requires increased planning. Furthermore, patient care delivery and financing of health care have been stimulated and dramatically changed because of advanced technology. Moreover, ambulatory care has increased which certain procedures used to be more of an impatient procedures basis (Berkman, 1996). As a result, in addressing the needs of patients for preventive, curative, and rehabilitative services, social workers must be a member of the health team.

At the same time, social workers will become community liaison, consultant, community organizer, collaborator, educator, discharge planner, resource mobilizer, caseworker, and counselor. As a holistic focus, social workers must place emphasis on stress management, time management, self empowerment, research knowledge, conflict resolution, coalition building, resource development, community development, culturally sensitive practice, and working under managed care. Social work profession is a quintessential ingredient in the 21st century health care.

Clinical practice guidelines in health care effect social workers. The presence or absence of social work in health care can dictate this future profession. More importantly, health care cannot be at its best if it ignores psychosocial factors from a social work perspective. However, behavioral and psychosocial factors in the development and resolution of illness have been ignored according to present guidelines (Ewalt, 1995). Even more, social and behavioral factors does not enter the equation in clinical practice guidelines, although, research demonstrate a relationship between social support and the quality and length of life. Consequently, questions which effect psychosocial well-being or effects of psychosocial interventions on health outcomes are

not asked in traditional biomedical research (Ewalt, 1995). The prescriptions mostly include the psychosocial aspects more than a strictly biomedical approach to illness. The multidisciplinary research clarifies the relationship of psychosocial factors and health.

In essence, the quality of the social work profession and research in health care has significant consequences for the future of social work practice.

APPENDICES

APPENDIX A

Tables

Table A1

How old are you?

Age	Black	White	Total
18-29	4 (26.7%)	2 (13.3%)	**6**
30-39	5 (33.3%)	3 (20.0%)	**8**
40-49	5 (33.3%)	4 (26.7%)	**9**
50-59	1 (6.7%)	5 (33.3%)	**6**
60-69	0	1 (6.7%)	**1**

Table A2

How would you describe your race or ethnic background?

Ethnic Background	African American	Caucasian
Black	15	15
White	15	15
Total	**30**	**30**

Table A3

What is the highest level of education you have completed?

Education	Black	White	Total
Completed High	4 (26.7%)	0	**4**
Technical Vocational	2 (13.3%)	2 (13.3%)	**4**
Some College	7 (46.7%)	7 (46.7%)	**14**
Completed College	2 (13.6%)	5 (33.3%)	**7**
Graduate School	0	1 (6.7%)	**1**
Doctoral	0	0	**0**

Table A4

Marital Status

Marital Status	Black	White	Total
Single	2 (13.3%)	1 (6.7%)	**3**
Married	10 (66.7%)	11 (73.3%)	**21**
Divorced	2 (13.3%)	1 (6.7%)	**3**
Separated	0	1 (6.7%)	**1**
Widow	1 (6.7%)	1 (6.7%)	**2**

Table A5

Employment Status

Employment Status	Black	White	Total
Employed	12 (80.0%)	7 (46.7%)	**19**
Unemployed	1 (6.7%)	0	**1**
Homemaker	2 (13.3%)	7 (46.7%)	**9**
Student	0	0	**0**
Other	0	1	**1**

Table A6

Insurance

Insurance	Black	White	Total
Insured	14 (93.3%)	12 (80.0%)	**26**
Uninsured	1 (6.7%)	1 (6.7%)	**2**
Medicare	0	2 (13.3%)	**2**
Medicaid	0	0	**0**
Medicare/Medicaid	0	0	**0**
Other	0	0	**0**

Table A7

Income

Income	Black	White	Total
Less than 5,000	1 (6.7%)	1 (6.7%)	**2**
5,000-10,000	0	1 (6.7%)	**1**
10,000-20,000	1 (6.7%)	2 (13.3%)	**3**
20,000-30,000	6 (40.0%)	3 (20.0%)	**9**
30,000-40,000	5 (33.3%)	3 (20.0%)	**8**
40,000-50,000	1 (6.7%)	3 (20.0%)	**4**
60,000-70,000	1 (6.7%)	1 (6.7%)	**2**
90,000-More	0	1 (6.7%)	**1**

Table A8

Have you ever had a clinical breast exam, that is, a healthcare provider ever examined your breast?

Race	Yes	No	Not Sure
Black	15 (100.0%)	0	**0**
White	13 (86.7%)	2	**0**
Total	28	2	**0**

Table A9

Have you ever had a mammogram, that is an X-ray of your breast?

Race	Yes	No
Black	12 (80.0%)	3 (20.0%)
White	10 (66.7%)	5 (33.3%)
Total	**22**	**8**

Table A10

What was the month and year of your last mammogram?

Mammogram/X-Ray	Black	White	Total
Not Sure	0	1 (6.7%)	1
Never	3 (20.0%)	5 (33.3%)	8
January 1980	1 (6.7%)	0	1
April 1995	0	1 (6.7%)	1
June 1996	0	1 (6.7%)	1
June 1997	0	1 (6.7%)	1
February 1998	6 (40.0%)	3 (20.0%)	9
April 1998	1 (6.7%)	3 (20.0%)	4
May 1998	1 (6.7%)	1 (6.7%)	2
June 1998	1 (6.7%)	1 (6.7%)	2

Table A11

How often do you thing a women of your age should have a mammogram?

How Often	Black	White	Total
Every 6 Months	0	1 (6.7%)	1
Every Year	11 (73.3%)	5 (33.3%)	16
Every 2 Years	2 (13.3%)	4 (26.7%)	6
Every 3 Years	1 (6.7%)	2 (13.3%)	3
Not Needed	1 (6.7%)	1 (6.7%)	2
Not Sure	0	2 (13.3%)	2

Table A12

Do you ever examine your breasts for lumps?

Race	Yes	No	Not Sure
Black	14 (93.3%)	1 (6.7%)	1 (6.7%)
White	12 (80.0%)	3 (20.0%)	2 (13.3%)
Total	**26**	**4**	**3**

Table A13

How often do you check your breasts for lumps?

Race	Monthly	Occasionally	Never
Black	9 (60.0%)	6 (40.0%)	0
White	6 (40.0%)	5 (33.3%)	4 (26.7%)
Total	**15**	**11**	**4**

Table A14

Have you ever been taught how to examine your breasts?

Race	Yes	No	Not Sure
Black	4 (26.7%)	11 (73.3%)	0
White	3 (20.0%)	12 (80.0%)	0
Total	**7**	**23**	**0**

Table A15

Have you ever had a breast biopsy, that is, a piece of your breast tissue removed by surgery or a needle?

Race	Yes	No	Not Sure
Black	14 (93.3%)	1 (6.7%)	0
White	12 (80.0%)	3 (20.0%)	0
Total	**26**	**4**	**0**

Table A16

Do you have a primary care provider?

Race	Yes	No	Not Sure
Black	13 (86.7%)	2 (13.3%)	1 (6.7%)
White	12 (80.0%)	3 (20.0%)	2 (13.3%)
Total	**25**	**5**	**3**

Table A17

Have you or any of your close relatives ever been diagnosed with breast cancer?

Relatives	Black	White	Total
Mother	4 (26.7%)	2 (13.3%)	**6**
Daughter	2 (13.3%)	7 (46.7%)	**9**
Sister	0	2 (13.3%)	**2**
Aunt	2 (13.3%)	2 (13.3%)	**4**
Grandmother	2 (13.3%)	1 (6.7%)	**3**
Cousin	4 (26.7%)	1 (6.7%)	**5**
Other	1 (6.7%)	0	**1**

Table A18

Are you presently due for a mammogram?

Due For Mammogram	Yes	No
Black	8 (53.3%)	7 (46.7%)
White	5 (33.3%)	10 (66.7%)
Total	**13**	**17**

Table A19

Are you able to pay for a mammogram?

Race	Yes	No	Not Sure
Black	10 (66.7%)	3 (20.0%)	2 (13.3%)
White	14 (93.3%)	1 (6.7%)	0
Total	24	4	2

Table A20

What are your chances of getting breast cancer in the next 10 years?

Race	Black	White	Total
Excellent	1 (6.7%)	1 (6.7%)	**2**
Good	4 (26.7%)	5 (33.3%)	**9**
Fair	5 (33.3%)	8 (53.3%)	**13**
Poor	5 (33.3%)	1 (6.7%)	**6**

Table A21

If a woman gets breast cancer, what do you feel her chances are being cured?

Race	Excellent	Good	Fair	Poor
Black	3 (20.0%)	7 (46.7%)	5 (33.3%)	0
White	4 (26.7%)	9 (60.0%)	2 (13.3%)	0
Total	**7**	**16**	**7**	**0**

Table A22

Being happy with my life.

Life	1.00-4.00	5.00-8.00	9.00-12.00	13.00-16.00
Black	13 (86.7%)	2 (13.3%)	1 (6.7%)	0
White	10 (66.7%)	2 (13.3%)	1 (6.7%)	3 (20.0%)
Total	**23**	**4**	**2**	**3**

Table A23

Being happy with my family.

Happy	6.00	7.00	8.00	11.00	16.00
Black	1 (6.7%)	1 (6.7%)	1 (6.7%)	0	0
White	1 (6.7%)	0	0	1 (6.7%)	1 (6.7%)
Total	**2**	**1**	**1**	**1**	**1**

Table A24

Being close to God.

God	Black	White	Total
1.00	14 (93.3%)	11 (73.3%)	**25**
2.00	0	1 (6.7%)	**1**
3.00	0	1 (6.7%)	**1**
4.00	0	1 (6.7%)	**1**
12.00	1 (6.7%)	0	**1**
15.00	0	1 (6.7%)	**1**

Table A25

Being healthy

Health	Black	White	Total
1.00	1 (6.7%)	0	**1**
2.00	3 (20.0%)	2 (13.3%)	**5**
3.00	3 (20.0%)	0	**3**
4.00	4 (26.7%)	5 (33.3%)	**9**
5.00	2 (13.3%)	3 (20.0%)	**5**
6.00	0	1 (6.7%)	**1**
7.00	1 (6.7%)	2 (13.3%)	**3**
10.00	1 (6.7%)	1 (6.7%)	**2**

Table A26

Becoming Rich

Rich	Black	White	Total
3.00	1 (6.7%)	1 (6.7%)	**2**
5.00	1 (6.7%)	0	**1**
7.00	1 (6.7%)	0	**3**
8.00	0	2 (13.3%)	**1**
9.00	1 (6.7%)	1 (6.7%)	**2**
10.00	1 (6.7%)	1 (6.7%)	**2**
11.00	2 (13.3%)	0	**2**
12.00	6 (40.0%)	8 (53.3%)	**14**

Table A27

Having Kids

Kid	Black	White	Total
2.00	0	1 (6.7%)	**1**
3.00	0	1 (6.7%)	**1**
4.00	0	2 (13.3%)	**2**
5.00	2 (13.3%)	1 (6.7%)	**3**
6.00	3 (20.0%)	2 (13.3%)	**5**
8.00	3 (20.0%)	3 (20.0%)	**6**
9.00	0	1 (6.7%)	**1**
10.00	4 (26.7%)	2 (13.3%)	**6**

Table A28

Having a good love life

Love Life	Black	White	Total
2.00	0	1 (6.7%)	**1**
4.00	1 (6.7%)	0	**1**
5.00	2 (13.3%)	2 (13.3%)	**4**
6.00	0	2 (13.3%)	**2**
7.00	3 (20.0%)	3 (20.0%)	**6**
9.00	4 (26.7%)	2 (13.3%)	**6**
10.00	0	1 (6.7%)	**1**
12.00	3 (20.0%)	4 (26.7%)	**7**

Table A29

Having enough money

Money	Black	White	Total
2.00	1 (6.7%)	1 (6.7%)	**2**
4.00	1 (6.7%)	1 (6.7%)	**2**
5.00	2 (13.3%)	2 (13.3%)	**4**
6.00	5 (33.3%)	0	**5**
7.00	3 (20.0%)	8 (53.3%)	**11**
9.00	0	4 (26.7%)	**4**
10.00	0	0	**0**
12.00	3 (20.0%)	0	**3**

Table A30

A good education for my children

Money	Black	White	Total
1.00	14 (93.3%)	11 (73.3%)	**25**
2.00	0	1 (6.7%)	**1**
3.00	0	1 (6.7%)	**1**
4.00	0	1 (6.7%)	**1**
12.00	1 (6.7%)	0	**1**
15.00	0	1 (6.7%)	**1**

Table A31

Getting along with others

Along with Others	Black	White	Total
3.00	1 (6.7%)	0	**1**
5.00	0	1 (6.7%)	**1**
6.00	1 (6.7%)	3 (20.0%)	**4**
8.00	4 (26.7%)	2 (13.3%)	**6**
9.00	1 (6.7%)	3 (20.0%)	**4**
10.00	3 (20.0%)	2 (13.3%)	**5**
11.00	1 (6.7%)	1 (6.7%)	**1**
12.00	0	2 (13.3%)	**2**
13.00	1 (6.7%)	0	**1**
14.00	1 (6.7%)	1 (6.7%)	**2**

Table A32

Enjoying your job

Job	Black	White	Total
2.00	0	1 (6.7%)	**1**
5.00	2 (13.3%)	0	**2**
6.00	0	1 (6.7%)	**1**
7.00	1 (6.7%)	1 (6.7%)	**2**
8.00	1 (6.7%)	2 (13.3%)	**3**
9.00	3 (20.0%)	0	**3**
10.00	0	1 (6.7%)	**1**
11.00	3 (20.0%)	3 (20.0%)	**6**
12.00	3 (20.0%)	1 (6.7%)	**4**
13.00	1 (6.7%)	3 (20.0%)	**4**
14.00	1 (6.7%)	0	**1**
15.00	0	2 (13.3%)	**2**

Table A33

Living a long time

Living	Black	White	Total
3.00	0	1 (6.7%)	**1**
4.00	4 (26.7%)	0	**4**
6.00	0	1 (6.7%)	**1**
8.00	1 (6.7%)	0	**1**
9.00	0	1 (6.7%)	**1**
10.00	3 (20.0%)	1 (6.7%)	**4**
12.00	1 (6.7%)	1 (6.7%)	**2**
13.00	2 (13.3%)	1 (6.7%)	**3**
14.00	1 (6.7%)	5 (33.3%)	**6**

Table A34

Making and keeping good friends

Living	Black	White	Total
2.00	0	1 (6.7%)	**1**
3.00	0	1 (6.7%)	**1**
4.00	0	2 (13.3%)	**2**
5.00	2 (13.3%)	1 (6.7%)	**3**
6.00	3 (20.0%)	2 (13.3%)	**5**
8.00	3 (20.0%)	3 (20.0%)	**6**
9.00	0	1 (6.7%)	**1**
10.00	4 (26.7%)	2 (13.3%)	**6**

Table A35

Enjoying free time

Free Time	Black	White	Total
5.00	1 (6.7%)	2 (13.3%)	**3**
6.00	1 (6.7%)	0	**1**
8.00	1 (6.7%)	1 (6.7%)	**2**
9.00	1 (6.7%)	0	**1**
10.00	1 (6.7%)	0	**1**
11.00	2 (13.3%)	1 (6.7%)	**3**
12.00	3 (20.0%)	1 (6.7%)	**4**
13.00	2 (13.3%)	5 (33.3%)	**7**
14.00	1 (6.7%)	2 (13.3%)	**3**
15.00	2 (13.3%)	2 (13.3%)	**4**
16.00	0	1 (6.7%)	**1**

Table A36

Having a good job

Good Job	Black	White	Total
2.00	0	1 (6.7%)	**1**
3.00	1 (6.7%)	0	**1**
6.00	1 (6.7%)	2 (13.3%)	**3**
7.00	1 (6.7%)	0	**1**
9.00	1 (6.7%)	1 (6.7%)	**2**
10.00	0	2 (13.3%)	**2**
11.00	2 (13.3%)	2 (13.3%)	**4**
12.00	1 (6.7%)	2 (13.3%)	**3**
13.00	1 (6.7%)	2 (13.3%)	**3**
14.00	2 (13.3%)	3 (20.0%)	**5**
16.00	0	1 (6.7%)	**1**

Table A37

Looking good

Looking Good	Black	White	Total
1.00	0	1 (6.7%)	**1**
7.00	2 (13.3%)	1 (6.7%)	**3**
9.00	0	1 (6.7%)	**1**
10.00	2 (13.3%)	1 (6.7%)	**3**
11.00	2 (13.3%)	2 (13.3%)	**4**
12.00	0	3 (20.0%)	**3**
13.00	3 (20.0%)	1 (6.7%)	**4**
14.00	1 (6.7%)	0	**1**
15.00	1 (6.7%)	4 (26.7%)	**5**
16.00	4 (26.7%)	1 (6.7%)	**5**

Table A38

Which is more effective for finding cancer early?

Race	Mammogram	A breast exam by medical person
Black	7 (46.7%)	8 (53.3%)
White	9 (60.0%)	6 (40.0%)
Total	**16**	**14**

Table A39

Which Is More Effective For Finding Cancer Early?

Race	Mammogram	A breast self-exam
Black	13 (86.7%)	2 (13.3%)
White	14 (93.3%)	1 (6.7%)
Total	**27**	**3**

Table A40

What about safety, would you say it is safe enough to get a mammogram every year?

Race	Yes	No	Not Sure
Black	14 (93.3%)	0	1 (6.7%)
White	11 (73.3%)	2 (13.3%)	2 (13.3%)
Total	**25**	**2**	**3**

Table A41

Do you think mammograms are uncomfortable?

Race	Yes	No	Not Sure
Black	11 (73.3%)	3 (20.0%)	1 (6.7%)
White	11 (73.3%)	2 (13.3%)	2 (13.3%)
Total	**22**	**5**	**3**

Table A42

Compared to others my age, my likelihood of developing breast cancer is a possibility:

Race	Agree	Disagree	Not Certain
Black	9 (60.0%)	3 (20.0%)	3 (20.0%)
White	8 (53.3%)	3 (20.0%)	4 (26.7%)

Table A43

It is likely that I will develop breast cancer sometime in my life.

Race	Agree	Disagree	Not Certain
Black	3 (20.0%)	6 (40.0%)	6 (40.0%)
White	4 (26.7%)	1 (6.7%)	10 (66.7%)
Total	**7**	**7**	**16**

Table A44

I would not need a mammogram because I check my own breast.

Race	Agree	Disagree	Not Certain
Black	1 (6.7%)	14 (93.3%)	0
White	0	14 (98.3%)	1 (6.7%)
Total	**1**	**28**	**1**

Table A45

I would not need a mammogram because I have doctor checks-ups.

Race	Agree	Disagree	Not Certain
Black	1 (6.7%)	13 (86.7%)	1 (6.7%)
White	0	15 (100.0%)	0
Total	**1**	**28**	**1**

Table A46

If I did not have a lump in my breast I would not need a mammogram.

Race	Agree	Disagree	Not Certain
Black	15 (100.0%)	0	0
White	14 (93.3%)	1 (6.7%)	0
Total	**29**	**1**	**0**

Table A47

If I had breast cancer my whole life would change.

Race	Agree	Disagree	Not Certain
Black	6 (40.0%)	5(33.3%)	4 (27.7%)
White	11 (73.3%)	4 (26.7%)	0
Total	**27**	**9**	**4**

Table A48

Breast cancer would not be that bad because I have faith in God.

Race	Agree	Disagree	Not Certain
Black	8 (53.3%)	4 (26.7%)	3 (20.0%)
White	7 (46.7%)	6 (40.0%)	2 (13.3%)
Total	**15**	**10**	**5**

Table A49

If I had breast cancer I would worry about not having a breast.

Race	Agree	Disagree	Not Certain
Black	6 (40.0%)	4 (26.7%)	5 (33.3%)
White	8 (53.3%)	5 (33.3%)	2 (13.3%)
Total	**14**	**9**	**7**

Table A50

If I had breast cancer it would not affect my life.

Race	Agree	Disagree	Not Certain
Black	2 (13.3%)	11 (73.3%)	2 (13.3%)
White	3 (20.0%)	12 (80.0%)	0
Total	**5**	**23**	**2**

Table A51

If I had breast cancer I would die.

Race	Agree	Disagree	Not Certain
Black	1 (6.7%)	11 (73.3%)	3 (20.0%)
White	1 (6.7%)	10 (66.7%)	4 (26.7%)
Total	**2**	**21**	**7**

Table A52

If I had breast cancer I would lose my breast.

Race	Agree	Disagree	Not Certain
Black	1 (6.7%)	8 (53.3%)	6 (40.0%)
White	3 (20.0%)	4 (26.7%)	8 (53.3%)
Total	**4**	**12**	**14**

Table A53

If I had breast cancer I would be worried or depressed.

Race	Agree	Disagree	Not Certain
Black	2 (13.3%)	7 (46.7%)	6 (40.0%)
White	8 (53.3%)	3 (20.0%)	4 (26.7%)
Total	**10**	**10**	**10**

Table A54

Not having the time would keep me from having a mammogram.

Race	Agree	Disagree	Not Certain
Black	1 (6.7%)	14 (93.3%)	0
White	2 (13.3%)	13 (86.7%)	0
Total	**3**	**27**	**0**

Table A55

Since I would never agree to have surgery I would not have a mammogram.

Race	Agree	Disagree	Not Certain
Black	15 (100.0%)	0	0
White	13 (86.7%)	2 (13.3%)	0
Total	**28**	**2**	**0**

Table A56

Not having enough money would keep me from having a mammogram.

Race	Agree	Disagree	Not Certain
Black	0	15 (100.0%)	0
White	2 (13.3%)	11 (73.3%)	2 (13.3%)
Total	**2**	**26**	**2**

Table A57

I would not want to have a mammogram because I would not want to know if I had cancer.

Race	Agree	Disagree	Not Certain
Black	0	15 (100.0%)	0
White	1 (6.7%)	14 (93.3%)	1 (6.7%)
Total	**1**	**29**	**1**

Table A58

I would not agree to have a mammogram/I'm afraid.

Race	Agree	Disagree	Not Certain
Black	15 (100.0%)	0	0
White	15 (100.0%)	0	0
Total	**30**	**0**	**0**

Table A59

I would not have a mammogram because it is too painful.

Race	Agree	Disagree	Not Certain
Black	14 (93.3%)	1 (6.7%)	0
White	14 (93.3%)	0	1 (6.7%)
Total	**28**	**1**	**1**

Table A60

If I had breast cancer I would not agree to have breast surgery.

Race	Agree	Disagree	Not Certain
Black	1 (6.7%)	11 (73.3%)	1 (6.7%)
White	1 (6.7%)	11 (73.3%)	0
Total	**2**	**22**	**1**

Table A61

I want a mammogram to find out if I am OK.

Race	Yes	No	Not Sure
Black	15 (100.0%)	0	0
White	13 (86.7%)	2 (13.3%)	0
Total	**28**	**2**	**0**

Table A62

I would want a mammogram because it may help the doctor stop the cancer before it is too late.

Race	Agree	Disagree	Not Certain
Black	15 (100.0%)	0	0
White	14 (93.3%)	1 (6.7%)	0
Total	**29**	**1**	**0**

Table A63

I would want a mammogram because it could help save my life.

Race	Agree	Disagree	Not Certain
Black	15 (100.0%)	0	0
White	13 (86.7%)	2 (13.3%)	0
Total	**28**	**2**	**0**

Table A64

I would want a mammogram because It could save my life.

Race	Agree	Disagree	Not Certain
Black	15 (100.0%)	0	0
White	13 (86.7%)	1 (6.7%)	1 (6.7%)
Total	**28**	**1**	**1**

Table A65

I would want a mammogram because it would give me "peace of mind".

Race	Agree	Disagree	Not Certain
Black	15 (100.0%)	0	0
White	13 (86.7%)	2 (13.3%)	0
Total	**28**	**2**	**0**

Table A66

I would want a mammogram because it could help save my breasts.

Race	Agree	Disagree	Not Certain
Black	15 (100.0%)	0	0
White	13 (86.7%)	2 (13.3%)	0
Total	**28**	**2**	**0**

APPENDIX B

Permission Letter for Pastor of the Church to Conduct Study

December 1, 1998

Pastor Randy Kea
Forest Park Church of Christ
5238 Phillips Drive
Forest Park, Georgia 30260

Dear Pastor Kea:

I'm a graduate student receiving a Masters of Social Work degree. I'm conducting a study for a thesis. The study is focused on women's awareness and knowledge of breast cancer. A questionnaire is used to gather data. The questionnaire is anonymous. The results of this study will help to determine how to intervene and educate the community about the importance of breast cancer exams. A completed copy of the study will be given to the church participants for review. Therefore with your written consent, it gives the researcher permission to administer the test to your church members.

Thank you in advance for your effort.

Lisa Benton
M.S.W. Second Year Graduate

Hattie M. Mitchell, MSW/LCSW
Assistant Professor

APPENDIX C

Permission Letter for Pastor of the Church to Conduct Study

December 8, 1998

Co-Pastor Edward Clark
Liveoak Baptist Church
2701 Flat Shoals Road
College Park, Georgia 30349

Dear Co-Pastor Clark:

I'm a graduate student receiving a Masters of Social Work degree. I'm conducting a study for a thesis. The study is focused on women's awareness and knowledge of breast cancer. A questionnaire is used to gather data. The questionnaire is anonymous. The results of this study will help to determine how to intervene and educate the community about the importance of breast cancer exams. A completed copy of the study will be given to the church participants for review. Therefore with your written consent, it gives the researcher permission to administer the test to your church members.

Thank you in advance for your effort.

Lisa Benton
M.S.W. Second Year Graduate

Hattie M. Mitchell, MSW/LCSW
Assistant Professor

APPENDIX D

Response Letter from Pastor of the Church to Conduct Study

December 1, 1998

Pastor Randy Kea
Church of Christ Forest Park
5238 Phillips Drive
Forest Park, Georgia 30260

Dear Pastor Kea:

I Randy Kea Pastor Randy Kea give Lisa Benton permission to administer a test to our church members. I understand that she is a graduate student receiving a Master of Social Work degree. I'm aware that she is conducting a study for a thesis. The study is focused on women's awareness and knowledge of breast cancer. The questionnaire is used to gather data. The questionnaire is anonymous. The results of this study will help to determine how to intervene and educate the community about the importance of breast cancer exams. A completed copy of the study will be given to the church participants for review. Therefore with my written consent, it gives the researcher permission to administer the test to my church members.

Lisa Benton
M.S.W. Second Year Graduate

Hattie M. Mitchell, MSW/LCSW
Assistant Professor

APPENDIX E

Response Letter from Pastor of the Church to Conduct Study

December 8, 1998

Co-Pastor Edward Clark
Liveoak Baptist Church
2701 Flat Shoals Road
College Park, Georgia 30349

Dear Co-Pastor Clark:

I Edward M. Clark Co-Pastor Edward Clark give Lisa Benton permission to administer a test to our church members. I understand that she is a graduate student receiving a Master of Social Work degree. I'm aware that she is conducting a study for a thesis. The study is focused on women's awareness and knowledge of breast cancer. The questionnaire is used to gather data. The questionnaire is anonymous. The results of this study will help to determine how to intervene and educate the community about the importance of breast cancer exams. A completed copy of the study will be given to the church participants for review. Therefore with my written consent, it gives the researcher permission to administer the test to my church members.

Lisa Benton
M.S.W. Second Year Graduate

Hattie M. Mitchell, MSW/LCSW
Assistant Professor

APPENDIX F

Letter to the Subjects for Participation

December, 1998

Dear Participant:

I'm a graduate student receiving a Masters of Social Work degree. I'm conducting a study for a thesis. The study is focused on women's awareness and knowledge of breast cancer. A questionnaire is used to gather data. The questionnaire is anonymous. The results of this study will help to determine how to intervene and educate the community about the importance of breast cancer exams. A completed copy of the study will be given to the church participants for review. Therefore it is extremely important to be sincere and accurate about these answers. Yours answers will help other women. You may help a stranger, relative, or yourself.

Thank you in advance for your effort.

Lisa Benton
M.S.W. Second Year Graduate

Hattie M. Mitchell, MSW/LCSW
Assistant Professor

APPENDIX G

Questionnaire

Demographics

(Please Circle the Appropriate Answer)

1. How old are you?

18-29	50-59
30-39	60-69
40-49	70-Older

2. How would you describe your race or ethnic background?

African-American	Asian
Caucasian	Pacific Islander
Hispanic	Native American
Bi-racial	Other _____

3. What is the highest level of education you have completed?

None	Some College
Elementary (1-8)	Completed College
Less than 12 years	Graduate School
Completed High School	Doctoral
Technical/Vocational School	Other _____

4. Marital Status

Single	Separated
Married	Widowed
Divorced	

5. Employment Status:

Employed	Homemaker
Unemployed	Student
Other _____	

6. Insurance

Insured	Medicaid
Uninsured	Other _____
Medicare	

7. Income

Less than $5,000	$40,000-50,000
$5,000-10,000	$50,000-60,000
$10,000-20,000	$60,000-70,000
$20,000-30,000	$80,000-90,000
$30,000-40,000	$90,000 or More

Health Seeking Behaviors

8. Have you ever had a clinical breast exam, that is, a healthcare provider ever examined your breasts?

Yes No Not sure

9. Have you ever had a mammogram, that is, an X-ray of your breasts?

Yes No Nor sure

10. What was the month and year of your last mammogram?

Date _____ Not Sure Never

11. How often do you think a woman of your age should have a mammogram?

Every month	Every 3 years
Every 6 months	Mammogram is not needed
Every year	Not sure
Every 2 years	Other _____

12. Do you ever examine your breasts for lumps?

Yes No Not sure

13 How often do you check your breasts for lumps?

Everyday Occasionally

Every week Never
Monthly Other _____

14. Have you ever been taught how to examine your breasts?

Yes No Not sure

15. Have you ever had a breast biopsy, that is, a piece of your breast tissue removed by surgery or a needle?

Yes No Not sure

16. Do you have a primary care provider?

Yes No Not sure

17. Have you or any of your close relatives ever been diagnosed with breast cancer?

Yes No Not sure

Relatives: Mother Grandmother
Daughter(s) Cousin(s)
Sister(s) Other _____
Aunt(s)

18. Are you presently due for a mammogram?

Yes No Not sure

19. Are you able to pay for a mammogram?

Yes No Not sure

Perceptions (A)

20. What are your chances of getting breast cancer in the next 10 years?

Excellent Good Fair Poor

21. If a woman does get breast cancer, what do you feel her chances are of being cured?

Excellent Good Fair Poor

Perceptions (B)

Please rank the 16 concepts or priorities in order according to what you feel are the most important to the least important standards. (Please number each concept, begin with 1-16.)

22. _____ Being happy with my life
23. _____ Being happy with my family
24. _____ Being close to God
25. _____ Being healthy
26. _____ Becoming rich
27. _____ Having children
28. _____ Having a good love life
29. _____ Having enough money
30. _____ A good education for my children
31. _____ Getting along with others
32. _____ Enjoying your job
33. _____ Living a long time
34. _____ Making and keeping good friends
35. _____ Enjoying my free time
36. _____ Having a good job
37. _____ Looking good

Attitudes

38. What is more effective for finding breast cancer early?

    (A) A mammogram (B) A breast exam by a medical person

39. Which is more effective for finding breast cancer early?

    (A) A mammogram (B) A breast self-exam

40. What about safety, would you say it is safe enough to get a mammogram every year?

    Yes No Not sure

41. Do you think mammograms are uncomfortable?

    Yes No Not sure

SUSCEPTIBILITY

42. Compared to others my age, my likelihood of developing breast cancer is a possibility.

Agree Disagree Not certain

43. It is likely that I will develop breast cancer sometime in my life?

Agree Disagree Not certain

44. I would not need a mammogram because I check my own breasts.

Agree Disagree Not certain

45. I would not need a mammogram because I go to the doctor for check-ups.

Agree Disagree Not certain

46. If I did not have a lump in my breast I would not need a mammogram.

Agree Disagree Not certain

SEVERITY

47. If I had breast cancer my whole life would change.

Agree Disagree Not certain

48. Breast cancer would not be that bad because I have faith in God.

Agree Disagree Not certain

49. If I had breast cancer I would worry about not having a breast.

Agree Disagree Not certain

50. If I had breast cancer it would not affect my life.

Agree Disagree Not certain

51. If I had breast cancer I would die.

Agree Disagree Not certain

52. If I had breast cancer I would lose my breast.

Agree Disagree Not certain

53. If I had breast cancer I would be worried or depressed.

Agree Disagree Not certain

BARRIERS

54. Not having the time would keep me from having a mammogram.

Agree Disagree Not certain

55. Since I would never agree to have surgery I would not have a mammogram.

Agree Disagree Not certain

56. Not having enough money would keep me from having a mammogram.

Agree Disagree Not certain

57. I would not want to have a mammogram because I would not want to know if I had breast cancer.

Agree Disagree Not certain

58. I would not agree to have a mammogram because I'm afraid.

Agree Disagree Not certain

59. I would not have a mammogram because it is too painful.

Agree Disagree Not certain

60. If I had breast cancer I would not agree to have breast surgery.

Agree Disagree Not certain

MEDICAL BENEFITS

61. I would want a mammogram to find out if I am OK.

Agree Disagree Not certain

62. I would want a mammogram because it may help the doctor stop the breast cancer before it is too late.

Agree Disagree Not certain

63. I would want a mammogram because it could help save my life.

Agree Disagree Not certain

64. I would want a mammogram because it could save my life.

Agree Disagree Not certain

65. I would want a mammogram because it would give me "peace of mind."

Agree Disagree Not certain

66. I would want a mammogram because it could help save my breast.

Agree Disagree Not certain

Questionnaire Adapted:

Feldman, J.P. & Smith, R.A., Kovenock, D. (1991). A Study Guided By The Health Belief Model of the Predictors of Breast Cancer Screening Of Women Ages 40 And Older. Public Health, 106, 2.

Fulton, J.P., Buechner, J.S., Scott, H.D., DeBuono, B.A., MD., MPH, Feldman, J.P., MD., Smith, R.A., R.A., Ph.D., & Kovenock, D., ScM. (1991). A Study Gudied by the Health Belief Model of the Predictors of Breast Cancer Screening to Women Ages 40 and Older. Public Health Reports, 106, 410-409.

Morrison, S. (1994). East/West Breast Express Questionnaire. Georgia: Grady Breast Clinic.

Price, J.H., Desmond, M.S., Slenker, S., Smith, D., & Stewart, P.W. (1992). Urban Black Women's Perceptions Of Breast Cancer And Mammography. Journal Of Community Health. 17, 4.

Williams, G.A., Abbott, R.R., & Taylor, D.K. (1991). Using Focus Group Methodology To Develop Breast Cancer Screening Programs That Recruit African American Women. Journal Of Community Health, 22, 1.

REFERENCES

Acs, S. (1996). The Call for Change In Breast Cancer Screening Guidelines. American Journal of Public Health, 84, 10-17.

Airhihenbuwa, C.O. (1982). Health Promotion and Disease Prevention Strategies for African Americans A Conceptual Model. Health Issues In The Black Community. Approach (pp. 78-91). New York: Guilford.

Ansell, D., M.D. MPH, Lacey, L., RN, DrPh., Whitman, S., Ph.D., Chen, E., Ph.D. & Phillips, C., MD (1994). A Nurse-Delivered Intervention to Reduce Barriers to Breast and Cervical Cancer Screening in Chicago Inner City Clinics. Public Health Report, 109, 104-111.

Beisecker, A.E., Ph.D., Helming, L., MA, Graham, D., MSPH, & Moore, W.P., PhD. (1994). Attitudes of Oncologists, Oncology Nurses, and Patients from a Women's Clinic Regarding Medical Decision Making for Older and Younger Breast Cancer Patients. The Gerontologist, 34, 505-512.

Berkman, B. (1996). The Emerging Health Care World: Implications for Social Work Practice and Education. Social Work, 41, 541-551.

Burns, R.B., McCarthy, E.P., Freund, K..M., et al. (1996) African-American women don't get Mammograms as often as whites. Geriatrics, 51, 65-66.

Calle, E.E., Ph.D., Flanders, W.D., MD, ScD., Thun, M.J., MD, MPH., & Martin, L.M., MS (1993) Demographic Predictors of Mammography and Pap Smear Screening In US Women. American Journal of Public Health, 53-60.

Ell, K. (1996). Social Work and Health Care Practice and Policy: A Psychosocial Research Agenda. Social Work, 41, 583-592.

Ewalt, P.L. (1995). Clinical Practice Guidelines: Their Impact on Social Work in Health. Social Work, 40, 293.

Feldman, J.P. & Smith, R.A., Kovenock, D. (1991). A Study Guided by the Health Belief Model of the Predictors of Breast Cancer Screening of Women Ages 40 and Older. Public Health, 106, 2.

Forte, D.A., Community-Based Breast Cancer Intervention Program for Older African American Women in Beauty Salons. Public Health Reports, 110, 179-183.

Fuller, S.M., RD, MPH, McDermott, Ph.D., Roetzeheim, R.G., MD & Marty, P.J., Ph.D. (1992). Breast Cancer Beliefs of Women Participation in a Television-Promoted Mammography Screening Project. Public Health Reports, 107, 682-690.

Fulton, J.P., Ph.D., Buechner, J.S., Ph.D., Scott, H.D., DeBuono, B.A., MD, MPH, Feldman, J.P., MD., Smith, R.A., Ph.D., & Kovenock, D., ScM. (1991). A Study Guided by the Health Belief Model of the Predictors of Breast Cancer Screening of Women Ages 40 and Older. Public Health Reports, 106, 410-419.

Gibbs, I.C., MD (1999). Black Women's Health. (On-line). Web-Site Developed by Power Analysis, Inc.

Gross, R., Rabinowitz, J., Feldman, D., & Boerma, W. (1996). Primary Health Care Physicians' Treatment of Psychosocial Problems: Implications for Social Work. Health & Social Work, 89-95.

Heck, K.E., MPH, Wagner, D.K., Ph.D., Schatzkin, A., MD, DrPh, Devesa, S.S., Ph.D. & Breen, N., Ph.D. (1997). Socioeconomic Status and Breast Cancer Mortality, 1989 through 1993: An Analysis of Education Data from Death Certificates. American Journal of Public Health, 87, 1218-1222.

Hepworth, D.H., Rooney, R.H., & Larsen, J.A. (1997). Direct Social Work Practice. Pacific Grove, CA: Brooks/Cole Publishing Company.

Jellinek, M. (1998). Social Work in Health Care in the 21st Century. Health & Social Work, 23, 76.

Mandelblatt, J., MD, Andrews, H., Ph.D., Kerner, C., Ph.D., Zauber, A. & Ph.D., Burnett, W., MD. (1991). Determinants of Late Stage Diagnosis of Breast and Cervical Cancer: The Impact of Age, Race, Social Class, and Hospital Type. American Journal of Public Health, 81, 646-649.

Mandelblatt, J., MD, MPH, Traxler, M., MD, Lakin, P., NP, Kanetsky, P., MPH, Kao, R., MS, (1993). Targeting Breast and Cervical Cancer Screening to Elderly Poor Black Women: Who will participate? Preventive Medicine, 22, 20-33.

Morrison, S. (1994) East/West Breast Express Questionnaire. Georgia Grady Breast Clinic.

Price, J., H., Desmond, M.S., Slenker, S., Smith, D., & Stewart, P.W. (1992). Urban Black Women's Perceptions of Breast Cancer and Mammography. Journal of Community Health, 17, 4.

Secret, M., Jordan, A., & Ford, J. (1999). Empowerment Evaluation as a Social Work Strategy. Health & Social Work, 24, 120-127.

Sung, J.F., Ph.D., Coates, R.J., Ph.D., Williams, J.E., Med., Liff, J.M., Ph.D., Greenburg, R.S., MD, Ph.D., McGrady, G.A., MD, MPH, Avery, B.Y., Med., & Blumenthal, J., MD., MPH. (1992). Cancer Screening Intervention Among Black Women in Inner City Atlanta-Design of a Study. Public Health Reports, 107, 382-388.

Susan G. Komen Breast Cancer Foundation. (1999). African American Women's Initiative Strategizing A Path For The Future. Washington, DC: Author.

Taylor, V.M., MD, MPH, Taplin, S.HJ., MD, MPH, Urban, N., ScD, White, E., Ph.D., Mahloch, J., RN, Majer, K. Ph.D., McIerran, D., MS, & Peacock, S., BA. (1996). Community Organization to Promote Breast Cancer Screening Ordering by Primary Care Physicians. Journal Of Communicy Health, 21, 277-291.

Weisbrod, A.J. Proving Causation In Breast Cancer Cases. Trail, August 1996, at 54.

Wells, B.L., Ph.D., & Horm, J.W., MSc. (1992). Stage at Diagnosis in Breast Cancer: Race and Socioeconomic Factors. American Journal of Public Health, 82, 1383-1385.

Weschlsler, J.M., Grinnell, T.B., and Brown, C.T. (1981). Social Work Research And Evaluation. (Forth Edition). Itasca, Illinois: F.E. Peacock Publishers, Inc.

Williams, G.A., Abbott, R.R., & Taylor, D.K. (1993). Using Focus Group Methodology to Develop Breast Cancer Screening Programs that Recruit African American Women. Journal of Community Health, 22, 1.

Williams, D., Best, J.A., Taylor, D.W., Gilbert, J.R., Wilson, D., Lindsay, E., Singer, J., & Gregg, J. (1990). Social and Cultural Barriers to Cancer Screening for Women at Two Neighborhood Halth Center. Medical Anthropology Quarterly.

Zapka, J.G., ScD, Hosmer, D., Ph.D., Costanza, M.E., MD, Harris, D.R., Ph.D, and Stoddard, A., ScD. (1992). Changes in Mammography Use: Economic, Need, and Service Factors. American Journal of Public Health, 10, 477-482.